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ABSTRACT

Early Head Start (EHS) is a comprehensive program providing intensive services from before birth to age 3 to promote improved outcomes in child, family, staff, and community development. The third of a 3-volume series designed to share the experiences of the 17 EHS programs participating in the Early Head Start National Research and Evaluation Project, this report focuses on the extent to which the research programs were fully implemented as specified in the Revised Head Start Performance Standards. Chapter 1 of the report provides an overview of the Early Head Start program and the national evaluation, and describes the context in which the research programs have been implemented. Chapter 2 describes the methods and data used to assess the extent of early program implementation. Chapter 3 presents findings of the assessment of early implementation in early childhood development and health services, and preliminary data from observations of the community child care settings of Early Head Start children. Chapter 4 focuses on implementation of family and community partnerships. Chapter 5 details findings related to early implementation of program design and management. Chapter 6 summarizes findings and anticipates the next evaluation. Evaluation findings suggest that in Fall 1997, the research programs were at a very early stage of implementation, with many still

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putting some service and management systems in place, and all grappling with how to respond to families' changing service needs in the wake of welfare reform. Six programs had built upon previous experience serving families with young children to fully implement Early Head Start by Fall 1997. Eight programs had reached moderate implementation levels, and three were at low implementation levels. Challenges in implementation included completing home visits with most families and ensuring that community child care arrangements met the performance standards. Successes in implementing program requirements included offering individualized services and developing a strong staff development system. The report's two appendices contain the implementation checklists and rating scales. (Contains 11 references.) (KB)

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EARLY HEAD START®

RESEARCH

Leading the Way: Characteristics and Early Experiences of Selected Early Head Start Programs

Volume III: Program Implementation

PS 031441

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Administration for Children & Families
Administration on Children, Youth & Families
Commissioner's Office of Research and Evaluation
and the Head Start Bureau

Early Head Start
Research and Evaluation Project
Local—National Partnerships

Leading the Way: Characteristics and Early Experiences of Selected Early Head Start Programs

Volume III: Program Implementation

December 2000

The Commissioner's Office of Research and Evaluation
And the Head Start Bureau
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Early Head Start Implementation Study Reports and Primary Research Questions

***Leading the Way* Report:** *What were the characteristics and implementation levels of 17 EHS programs in fall 1997, soon after they began serving families?*

Executive Summary: *Summarizes Volumes I, II and III.*

Volume I: *Cross-Site Perspectives--What were the characteristics of EHS research programs in fall 1997, across 17 sites?*

Volume II: *Program Profiles--What were the stories of each of the EHS research programs?*

Volume III: *Program Implementation--To what extent were the programs fully implemented, as specified in the Revised Head Start Performance Standards, by fall 1997?*

***Pathways to Quality and Full Implementation* Report:** *What were the characteristics, levels of implementation, and levels of quality of the 17 EHS programs in fall 1999, three years into serving families? What pathways did programs take to achieve full implementation and high quality? This report will be released in fall 2000.*

This report was prepared for the Administration on Children, Youth and Families, U.S. Department of Health and Human Services (DHHS), under contract HHS-105-95-1936 to Mathematica Policy Research, Princeton, NJ. The contents of this report do not necessarily reflect the views or policies of DHHS, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

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CONTENTS

Chapter Page

I INTRODUCTION 1

A. EARLY HEAD START 2

B. THE EARLY HEAD START NATIONAL RESEARCH AND EVALUATION PROJECT 4

C. THE POLICY CONTEXT FOR EARLY HEAD START IMPLEMENTATION 6

D. PROGRAM APPROACHES 7

E. THE PROGRAM CONTEXT IN FALL 1997 8

II MEASURING THE EXTENT OF PROGRAM IMPLEMENTATION 11

A. DATA SOURCES FOR IMPLEMENTATION RATINGS 13

B. IMPLEMENTATION RATING SCALES 14

C. IMPLEMENTATION RATING PROCESS 16

D. OBSERVATIONS OF CHILD CARE SETTINGS 18

III IMPLEMENTATION OF EARLY CHILDHOOD DEVELOPMENT AND HEALTH SERVICES 21

A. IMPLEMENTATION OF EARLY CHILDHOOD DEVELOPMENT AND HEALTH SERVICES 21

  1. Developmental Assessments 25
  2. Individualization of Services 26
  3. Parent Involvement in Child Development Services 27
  4. Group Socialization Activities 28

CONTENTS *(continued)*

Chapter **Page**

III *(continued)*

5. Child Care 28
6. Health Services for Children 31
7. Frequency of Child Development Services 32

B. OBSERVATIONS OF QUALITY IN CENTER-BASED CHILD CARE SETTINGS 34

1. Child Care Quality in Early Head Start Centers 35
2. Child Care Quality in Community Child Care Centers Used by Early Head Start Families 40

IV FAMILY AND COMMUNITY PARTNERSHIPS 47

A. FAMILY PARTNERSHIPS 47

1. Individual Family Partnership Agreements 48
2. Availability of Services for Families 50
3. Frequency of Services for Families 52
4. Parent Involvement 52
5. Father Initiatives 53

B. COMMUNITY PARTNERSHIPS 55

1. Collaborative Relationships 57
2. Advisory Committees 57
3. Transition Planning 59

V PROGRAM DESIGN AND MANAGEMENT 61

A. STAFF DEVELOPMENT 61

1. Supervision 62
2. Training 65
3. Staff Retention 65
4. Compensation 66
5. Staff Morale 66

CONTENTS *(continued)*

Chapter **Page**

V *(continued)* B. MANAGEMENT SYSTEMS 67

1. Policy Council 69
2. Goals, Objectives, and Plans 69
3. Program Self-Assessment 71
4. Community Needs Assessment 71

VI SUMMING UP AND LOOKING AHEAD 73

A. EARLY IMPLEMENTATION CHALLENGES REFLECTED IN THE IMPLEMENTATION RATINGS 75

B. EARLY IMPLEMENTATION SUCCESSES REFLECTED IN THE IMPLEMENTATION RATINGS 80

C. LOOKING AHEAD 83

REFERENCES 85

APPENDIX A: IMPLEMENTATION CHECKLISTS A.1

APPENDIX B: IMPLEMENTATION RATING SCALES B.1

I. INTRODUCTION

In any program evaluation, knowing how the program was implemented is critical for understanding program impacts and for making recommendations for program improvements. The National Early Head Start Research and Evaluation Project is using several strategies to look into the operations of 17 research programs, including an assessment of the extent to which research programs have implemented Early Head Start, based on selected portions of the revised Head Start Program Performance Standards and the Early Head Start grant announcement. Our understanding of the Early Head Start intervention, and in particular the extent of program implementation, will help us design appropriate impact analyses, understand program impacts, and identify pathways to full implementation and high-quality services in the research programs.

This volume presents our findings on the extent of the research programs' implementation in fall 1997, two years after they were funded and one year after they began serving families. It is the third volume in a series of reports that describes the characteristics and implementation of the 17 Early Head Start research programs soon after they began serving families. The first two volumes describe the programs' expected outcomes and services delivered in each of the program areas (Volume I; ACYF 1999a) and present a descriptive profile of each of the 17 research programs (Volume II; ACYF 1999b). A second implementation report, to be completed later in 2000, will present findings on the extent of program implementation in fall 1999 and will describe the developmental pathways the 17 research programs followed over the first four years of Early Head Start program funding.

In this introductory chapter, we first provide a brief overview of the Early Head Start program and the national evaluation and then describe the policy and program context in which the 17 Early Head Start research programs have been implemented. In Chapter II, we describe the methods and data we used to assess the extent of early program implementation in Early Head Start research programs. Chapters III through V present the results of our assessment of early implementation in three major program areas--early childhood development and health services, family and community partnerships, and program design and management. Because Head Start program guidelines require that programs provide high-quality child care services as needed by children and families, either by providing these services directly or by helping families obtain appropriate child care in the community, Chapter III also presents preliminary data from observations of the child care settings of Early Head Start children in the research sample. A final chapter sums up what we have learned from our assessment of early program implementation in fall 1997 and looks ahead to our second assessment of program implementation in fall 1999.

A. EARLY HEAD START

Early Head Start, a new Head Start initiative to serve low-income pregnant women and families with infants and toddlers, began in 1995. The Administration on Children, Youth and Families (ACYF) designed the Early Head Start program in response to (1) the growing awareness of a "quiet crisis" facing families of infants and toddlers in the United States, as identified in the *Starting Points* report of the Carnegie Corporation of New York; (2) recommendations of the Advisory Committee on Head Start Quality and Expansion; (3) growing community needs for services for infants and toddlers; and (4) the 1994 Head Start reauthorization, which established a special initiative setting aside three percent of 1995 Head Start funding, four percent of 1996 and 1997 funding, and five percent of 1998 funding for services to families with infants and toddlers. Following the 1994 Head Start reauthorization, U.S. Department of Health and Human Services (DHHS) Secretary Donna Shalala's Advisory Committee on Services for Families with Infants and Toddlers set forth a vision and blueprint for Early Head Start programs. The 1998 Coats Human Services Reauthorization Act increased Early Head Start funding to 7.5 percent for fiscal year 1999, 8 percent for fiscal year 2000, 9 percent for 2001, and 10 percent for 2002 and 2003. Today more than 600 programs across the nation are serving pregnant women and families with infants and toddlers. More programs will be funded in 2000 and beyond as the Head Start Bureau increases the proportion of funds set aside for services for families with infants and toddlers.

Early Head Start is a child development program consisting of comprehensive, two-generation services that may begin before the child is born. Services focus on enhancing the child's development and supporting family members as primary educators of their children during the critical first three years of the child's life. Early Head Start programs are designed to produce outcomes in four domains:

1. ***Child development*** (including health, resiliency, and social, cognitive, and language development)
2. ***Family development*** (including parenting and relationships with children, the home environment and family functioning, family health, parent involvement, and economic self-sufficiency)
3. ***Staff development*** (including professional development and relationships with parents)
4. ***Community development*** (including enhanced child care quality, community collaboration, and integration of services to support families with young children)

The Wave I Early Head Start programs were funded in fall 1995. The early years of their grants were characterized by significant changes and many events. Some of these events required some of the young Early Head Start programs to make adjustments and, in a few cases, to redesign their service approach. Figure I.1 presents a timeline displaying the key events surrounding the implementation of Early Head Start.[1]

---

[1] Events below the dotted line occurred after the site visits in which the data described in this report were collected.

B. THE EARLY HEAD START NATIONAL RESEARCH AND EVALUATION PROJECT

In 1996 and 1997, ACYF selected 17 programs from around the country to participate in the Early Head Start National Research and Evaluation Project. Sixteen of the research programs received funding in fall 1995 (Wave I) and began enrolling families in summer 1996. One research program received funding in fall 1996 (Wave II) and began enrolling families in summer 1997. These programs constitute a balanced group--including Head Start agencies, former Comprehensive Child Development Programs, former Parent Child Centers, school districts, and community-based organizations; all 10 DHHS service regions; urban and rural areas; and variation in racial/ethnic makeups. The research programs broadly resemble the full group of programs that received Early Head Start funding in the first two waves in terms of enrollment and family demographics, based on comparisons with Head Start Program Information Report (PIR) data.[2] Thus, lessons from their implementation are likely to be applicable to other Early Head Start programs.

The Early Head Start National Research and Evaluation Project is being conducted by Mathematica Policy Research, Inc. and Columbia University in collaboration with 15 local research teams and is being coordinated by the Early Head Start Research Consortium. The research includes five major components: (1) an implementation study; (2) an impact evaluation, using an

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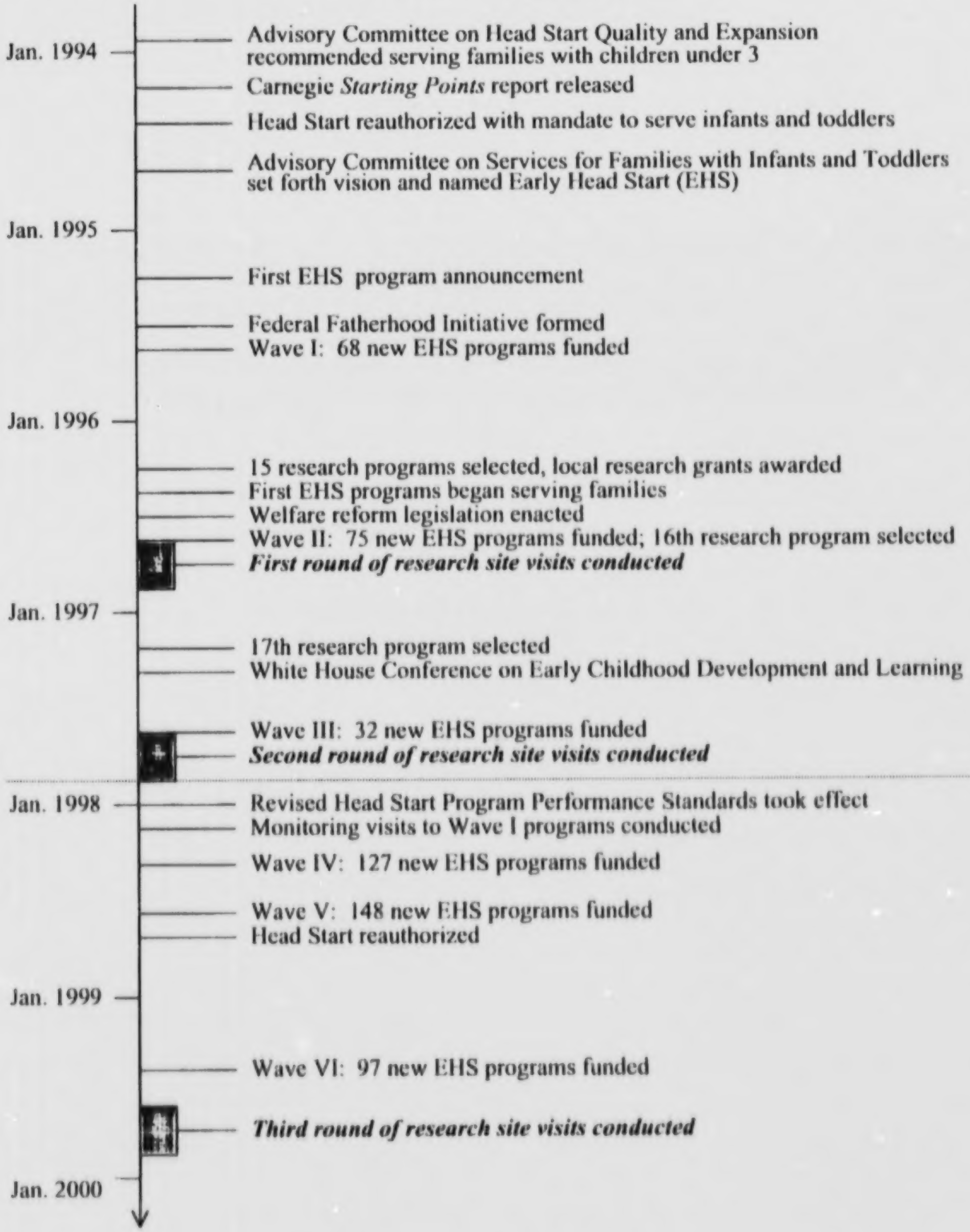
[2] For a more detailed description of these data, see *Leading the Way: Characteristics and Early Experiences of Selected Early Head Start Programs, Volume I: Cross-Site Perspectives*, pages 31-32 (Administration on Children, Youth, and Families 1999).

FIGURE I.1

KEY EVENTS IN THE IMPLEMENTATION OF EARLY HEAD START PROGRAMS AND RESEARCH



Jan. 1994
Advisory Committee on Head Start Quality and Expansion recommended serving families with children under 3
Carnegie *Starting Points* report released
Head Start reauthorized with mandate to serve infants and toddlers
Advisory Committee on Services for Families with Infants and Toddlers set forth vision and named Early Head Start (EHS)
Jan. 1995
First EHS program announcement
Federal Fatherhood Initiative formed
Wave I: 68 new EHS programs funded
Jan. 1996
15 research programs selected, local research grants awarded
First EHS programs began serving families
Welfare reform legislation enacted
Wave II: 75 new EHS programs funded; 16th research program selected
First round of research site visits conducted
Jan. 1997
17th research program selected
White House Conference on Early Childhood Development and Learning
Wave III: 32 new EHS programs funded
Second round of research site visits conducted
Jan. 1998
Revised Head Start Program Performance Standards took effect
Monitoring visits to Wave I programs conducted
Wave IV: 127 new EHS programs funded
Wave V: 148 new EHS programs funded
Head Start reauthorized
Jan. 1999
Wave VI: 97 new EHS programs funded
Third round of research site visits conducted
Jan. 2000

experimental design; (3) local research studies to learn about pathways to desired outcomes; (4) policy studies to respond to information needs in areas of emerging policy-relevant issues; and (5) continuous program improvement. The research aims to produce a knowledge base to inform the development of all Early Head Start programs.

C. THE POLICY CONTEXT FOR EARLY HEAD START IMPLEMENTATION

The early phases of the Early Head Start initiative were implemented during a time of fundamental changes in this country's social services systems. Early Head Start programs responded to these changes, in some cases by changing their service delivery approach and in some cases by changing the ways they collaborated with others in their communities. In particular, five broad social changes and contextual factors, some of which occurred after Early Head Start began, have been and are likely to continue influencing the Early Head Start initiative:

1. ***Increasing recognition of the importance of early development***, which has led to greater demand and support for services that start when women are pregnant and focus directly on child development

2. ***Welfare reform in the context of a strong economy***, which can increase parents' child care needs, increase levels of family stress, and make it more difficult for parents to participate in some program services

3. ***New child care and state-supported early childhood initiatives***, which can make it easier for families to obtain financial assistance, increase the need for Early Head Start staff members to collaborate with state child care administrators and local child care programs, and may make it more difficult for Early Head Start programs to hire and retain staff members

4. ***Growing attention to the roles of fathers in young children's lives***, which can lead programs to devote more resources than originally planned to strengthen fathers' relationships with their children and enhance fathers' parenting skills

5. ***Recent evaluation findings that identify challenges in improving outcomes for children and families***, which suggest that programs that provide intensive, purposeful, high-quality child-focused services are more likely than those that provide primarily

parent-focused services to promote significant change in children's cognitive, social, and emotional development

D. PROGRAM APPROACHES

Early Head Start programs strive to achieve their goals by designing program options based on family and community needs. Programs may offer one or more options to families, including (1) a home-based option, (2) a center-based option, (3) a combination option in which families receive a prescribed number of home visits and center-based experiences, and (4) locally designed options. Because a single program may offer multiple options to families, we have characterized *programs* for purposes of the research according to the options they offer to *families* as follows:

> ***Center-based programs***, which provide all services to families through the center-based option (center-based child development services plus other activities). These programs provide child development and child care services to children at their centers.
>
> ***Home-based programs***, which provide all services to families through the home-based option (home visits plus other activities). These programs provide child development services during weekly home visits and are responsible for ensuring that families that need child care find care in the community that meets the revised Head Start Program Performance Standards.
>
> ***Mixed-approach programs,***[3] which provide services to some families through the center-based option and to some families through the home-based option, or provide services to families through the combination option or a locally designed option. These programs are responsible for providing child care directly or helping families arrange child care in the community that meets the revised Head Start Program Performance Standards.

When the research programs were initially funded, five were center-based, five were home-based, and seven were mixed-approach (they served some families through the center-based option, other families through the home-based option, or some families through both). By fall 1997, eight programs were home-based, four were center-based, and five were mixed-approach. These changes in approach resulted from subsequent funding decisions made after the programs were initiated, shifts in families' needs, and recommendations of technical assistance providers. In some programs, changes are continuing to take place in response to changing family needs for child care and clearer ACYF expectations that Early Head Start programs are responsible for ensuring that all Early Head Start children who need child care receive care that meets the revised Head Start Program Performance Standards.

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[3] *Mixed approach* is a research term and is not used in the revised Head Start Program Performance Standards.

E. THE PROGRAM CONTEXT IN FALL 1997

In fall 1997, the national Early Head Start initiative and the 17 research programs were at a very early stage of program development. This was a dynamic period marked by the early implementation of welfare reform while ACYF was still putting the Early Head Start support infrastructure into place, including (1) preparing to implement the revised Head Start Program Performance Standards, (2) preparing for program monitoring to ensure compliance with the standards, and (3) refining training and technical assistance. These three aspects of the Early Head Start initiative's development--along with participation as research sites--contributed to the research programs' implementation of Early Head Start by fall 1997:

1. ***The revised Head Start Program Performance Standards had been announced but not yet put into effect.*** Early Head Start programs follow and are monitored according to the revised Head Start Program Performance Standards, which were published in November 1996 and took effect in January 1998 (U.S. Department of Health and Human Services, Administration for Children and Families 1996). In fall 1997, the programs were still seeking clarification of some of the new regulations.

2. ***Monitoring visits by the Head Start Bureau had not yet taken place.*** Head Start Bureau staff conduct monitoring visits every three years to determine whether programs are in compliance with program guidelines and performance standards, to clarify practices and procedures related to the standards, and to recommend program improvements. While programs received ongoing guidance from Head Start Bureau program officers during early implementation, Wave I Early Head Start programs were

first monitored in spring 1998, so some procedures in place in 1997 subsequently changed.

3. ***Training and technical assistance systems were not yet fully developed.***[4] In fall 1997, although the technical assistance system offered a broad range of training and support services to Early Head Start programs, technical assistance providers were still learning about Early Head Start program requirements. Training and technical assistance (T/TA) has been provided by the Early Head Start National Resource Center, administered by Zero to Three, and by the Head Start Training and Technical Assistance Network, which includes regional training centers that provide general program training and specific training for supporting program services for children with disabilities. Early technical assistance was not as intensive as planned, because the number of Wave I programs funded was greater than initially planned when the technical assistance contract was awarded. By 1998, a comprehensive T/TA system was in place that linked the National Resource Center and the Head Start Training and Technical Assistance Network and provided infant/toddler specialists within each U.S. Department of Health and Human Services region.

4. ***Participation in the Early Head Start Research and Evaluation Project complicated the task of implementation for the research programs.*** Random assignment required programs to recruit double the number of families they were funded to enroll and restricted enrollment to families with children under 12 months of age. In some communities, agencies were reluctant to refer families because they might not be randomly assigned to the program group. In fall 1997, some programs were still recruiting and enrolling families. In addition, while programs report that local research partners helped them think through expected outcomes and program services, research programs made significant investments in the process of building these partnerships, especially during the first two years of funding.

Thus, after approximately one year of providing Early Head Start services to children and families, in fall 1997 most research programs were still developing or fine-tuning their service delivery systems and in some cases seeking guidance and technical assistance from the Head Start Bureau. Some of the research programs, such as previous Comprehensive Child Development Programs and Parent Child Center programs, had to make major adjustments in their program focus or service mix. Other research programs, including several Head Start grantees, were serving families with infants and toddlers for the first time. All of the research programs were grappling with how to respond to the shifting needs of families in the wake of welfare reform, and some were contemplating significant adjustments to their service delivery approach. As reported in Volumes I and II of this report, however, programs were also offering many services consistent with the models they had proposed.

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[4] For a more detailed description of the Early Head Start training and technical assistance system in fall 1997, see *Leading the Way: Characteristics and Early Experiences of Selected Early Head Start Programs, Volume 1: Cross-Site Perspectives*, pages 6-7.

II. MEASURING THE EXTENT OF PROGRAM IMPLEMENTATION

The first step to measuring the extent of program implementation is establishing a clear definition of a fully implemented program. For purposes of this research, we defined the degree of implementation as the extent to which a program offers services meeting the requirements of selected key elements of the revised Head Start Program Performance Standards and the Early Head Start grant announcement. The degree of implementation across Early Head Start program components could vary within programs at any given point in time and especially during early stages of program development, reflecting variation in program emphases and levels of difficulty with implementing particular services in particular communities. Likewise, the degree of implementation of each program component could vary across programs, reflecting differences in program emphases and circumstances. The degree of implementation could also vary across programs in the early stages due to differences in programs' understanding of the revised Head Start Program Performance Standards. Again, in fall 1997, the performance standards were not yet official, and the Head Start Bureau had not yet used the standards to monitor programs.

The degree to which programs implement Early Head Start and the quality of the services they provide are intertwined. The Early Head Start grant announcement not only specified the types of services that programs must provide, but explicitly required programs to provide high-quality services. Thus, in order to determine the extent to which programs have met the federal government's vision for Early Head Start and have become fully implemented, we must assess both the degree to which Early Head Start research programs have implemented the required services and, to the extent we are able, the quality of the services provided. Because established measurement tools do not exist for assessing the quality of many Early Head Start services, and because of the importance of child care, we have focused our first assessment of service quality on center-based child care, drawing on the child care research literature for measuring quality. In the next implementation report, to be completed later in 2000, we will include updated quality assessments of both center-based and family child care. We will also include quality assessments of child development home visits, a key component of Early Head Start child development services in programs that serve families through the home-based or combination option.

To help us assess the extent of program implementation, we developed rating scales, checklists for organizing the information needed to assign ratings, and a process for assigning ratings to each research program. The rating scales are designed to help us reduce the large amount of implementation information into summary variables for testing hypotheses about how implementation relates to outcomes and to help us summarize the research programs' progress toward full implementation over time.

To assess the quality of center-based child care, we used an established quality measure--the Infant/Toddler Environment Rating Scale (ITERS) (Harms, Cryer, and Clifford 1990)--and examined structural quality indicators, including group sizes and child-staff ratios. The ITERS measures were collected in observations of center-based child care provided directly by Early Head Start research programs and observations of Early Head Start children's classrooms in community child care centers. These observations were made in connection with developmental assessments of children in the research sample at 14 and 24 months of age.

This chapter describes the process we followed for assessing the extent of program implementation in the Early Head Start research programs in fall 1997. We begin by describing the data sources we used in developing implementation ratings and then describe our methodology for developing the implementation rating scales and for assigning ratings to individual programs. A final section describes the instrument we used to conduct observations of child care centers used by Early Head Start families and the methodology we used for analyzing the preliminary observation data on child care quality presented in Chapter III.

A. DATA SOURCES FOR IMPLEMENTATION RATINGS

To assess the extent of program implementation, we relied primarily on information collected during site visits conducted in fall 1997. With one member of the site visit team visiting each program, site visitors conducted individual and group interviews with program staff, parents, community members, and local researchers; reviewed case files to learn about patterns of services provided to individual families; reviewed other program records; and observed service delivery during a home visit or in a program-operated child care center. In addition, all Early Head Start staff at the research programs completed a self-administered survey about their background, qualifications, education and training, and satisfaction with the work environment. To ensure consistency of data collection across individual programs while allowing site visitors to tailor discussion guides to the circumstances of individual programs, all six site visitors participated in a training session prior to the visits and followed discussion guides for conducting individual and group interviews while on-site.

To facilitate the assignment of implementation ratings for each program, site visitors assembled the site visit and staff survey information in checklists organized according to program components (Appendix A). In addition, site visitors wrote detailed program profiles based on information obtained during the visits. Program directors and their local research partners reviewed the profiles and checklists for their programs, provided corrections of erroneous information, and in some cases provided additional clarifying information.

B. IMPLEMENTATION RATING SCALES

To develop implementation rating scales, we identified specific criteria for determining the degree to which programs implemented Early Head Start's three major program areas: (1) early childhood development and health services, (2) family and community partnerships, and (3) program design and management. To refine our assessment, we created distinct criteria for both family and community partnerships. Likewise, within program design and management we created separate criteria for staff development and program management systems.

The criteria encompass key program requirements in the Early Head Start grant announcement issued on March 17, 1995, and the revised Head Start Program Performance Standards issued on November 5, 1996. Because the purpose of the ratings was to identify and track over time the key elements of program implementation and *not* to monitor compliance, we focused on the key requirements needed to help us identify pathways to full implementation and high-quality services and to summarize and quantify a large amount of qualitative information on program implementation. We reviewed our initial criteria with representatives of the Head Start Bureau and the Early Head Start technical assistance network to ensure that our criteria focused on an appropriate subset of program requirements. We also solicited comments from members of the Early Head Start Research Consortium. After incorporating the comments and suggestions we received, we finalized the criteria and converted them into rating scales for each of the five program components we examined (Appendix B). Table II.1 summarizes the program elements we assessed under each of the five program components.

For each program element, we created a rating scale containing up to five levels of implementation, ranging from minimal implementation (level 1) to enhanced implementation (level 5). We created fewer than five implementation levels in our rating scales for a few of the program

TABLE II.1

PROGRAM ELEMENTS INCLUDED IN THE EARLY HEAD START IMPLEMENTATION RATING SCALES

Scale	Program Element
Early Childhood Development and Health Services	Frequency of services Developmental assessments Health services Child care Parent involvement in child development services Individualization of services Group socialization activities (for home-based and mixed-approach programs)
Family Partnerships	Individualized family partnership agreements Availability of services Frequency of services Parent involvement Father initiatives
Community Partnerships	Collaborative relationships with other service providers Advisory committees Transition plans
Staff Development	Supervision Training Staff turnover Compensation Staff morale
Management Systems and Procedures	Policy council Goals, objectives, and plans Program self-assessment Community needs assessment

elements we examined, because our criteria were not complex enough to identify five distinct levels of implementation. For our analysis of program implementation, we considered programs rated at levels 1 through 3 to have reached partial implementation and programs rated at levels 4 and 5 to have reached full implementation of the particular program element rated. Table II.2 provides our definition for each rating level. We use the term "full implementation" as a research term to indicate that the program has substantially implemented most of the program elements.

C. IMPLEMENTATION RATING PROCESS

We designed a consensus-based approach to assigning implementation ratings to each Early Head Start research program. Following our 1997 site visits, we assembled a rating panel of four national evaluation team members and two outside experts. Each rating panel member was given responsibility for rating a subset of the research programs. For each program, the site visitor and two panel members reviewed the extensive documentation in more than 50 pages of checklists and written materials, and assigned ratings independently based on the program profile and the checklist. Once these independent ratings were completed for all programs, the rating panel met in May 1998 to review the three sets of ratings produced for each program, discuss differences in ratings across panel members, and assign consensus ratings for each program. During the course of this process, the rating panel made minor modifications to the rating scales to clarify ambiguities and create clearer distinctions between scores in some areas. The analyzes of the ratings we present in this report are based on the consensus ratings assigned in May 1998 by the rating team.

After we completed the rating process, we checked the validity of the consensus-based implementation ratings by comparing them to independent ratings. After the Head Start Bureau completed monitoring visits to all 17 research programs in spring 1998, we asked a member of the monitoring team to use information collected during the monitoring visits to rate the programs'

TABLE II.2

EARLY HEAD START IMPLEMENTATION RATING SCALE LEVELS

Level		Definition
Partial Implementation		
1	Minimal implementation	Program shows little or no evidence of effort to implement the relevant program element.
2	Low-level implementation	Program has made some effort to implement the relevant program element.
3	Moderate implementation	Program has implemented some aspects of the relevant program element.
Full Implementation		
4	Full implementation[a]	Program has substantially implemented the relevant program element.
5	Enhanced implementation	Program has exceeded expectations for implementing the relevant program element.

[a] We use the term "full implementation" throughout this report as a research term.

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implementation using the rating scales we developed. We did *not* share our rating results or information collected during our site visits with the monitoring team. The ratings assigned by the monitoring team member were very similar to those assigned by our rating panel and confirmed that our ratings provide a good assessment of program implementation.

D. OBSERVATIONS OF CHILD CARE SETTINGS

In addition to information gathered during site visits to the Early Head Start research programs in fall 1997, we now have preliminary data from observations of the child care settings of Early Head Start children in the research sample. Child care observations are being conducted when children reach 14, 24, and 36 months of age. The preliminary data include observations completed in conjunction with child assessments conducted with children who were 14 or 24 months of age and submitted for data entry by February 1999. Thus, these preliminary data pertain primarily to the research programs' first two years of serving families. The data include 162 classroom observations conducted in the nine Early Head Start research programs operating child care centers and 79 classroom observations in community child care centers caring for Early Head Start children from 14 research programs.

In Chapter III, we examine child care quality using the Infant/Toddler Environment Rating Scale (ITERS) (Harms, Cryer, and Clifford 1990). The ITERS consists of 35 items that assess the quality of center-based child care, including items in seven categories: (1) furnishings and display for children, (2) personal care routines, (3) listening and talking, (4) learning activities, (5) interaction, (6) program structure, and (7) adult needs.[1] Each item is ranked from 1 to 7. A ranking of 1 describes care that does not even meet custodial care needs, while a ranking of 7 describes excellent, high-quality personalized care. The definitions for quality used in the ITERS are consistent with the Accreditation Criteria and Procedures of the National Association for the Education of Young Children (NAEYC 1998) and the Child Development Associate (CDA) National Credentialing Program (Council for Professional Recognition 1996).

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[1] We excluded three items from the adult needs category (opportunities for professional growth, adult meeting area, and provisions for parents) as is customary in research using the ITERS.

To compute average ITERS scores for center-based child care provided directly by research programs, we began by averaging the observations over time for each classroom. Classrooms could have been observed as often as once per quarter (or more often if staff or children had changed since the last observation visit), depending on when Early Head Start children were in care. Once we calculated the average score for each classroom, we averaged the classroom scores for each center to generate a center score. If a program operated multiple centers, we then averaged the center scores to generate an average score for each research program.[2]

To compute average ITERS scores for child care provided in community child care centers used by Early Head Start families, we first computed an average score for each center used by a program family. As with Early Head Start centers, observations could have been conducted as often as once per quarter, depending on when children were in care. Then, we used the average scores for centers to calculate an average score for each research program.

Centers included in the scores for community child care centers represent a mix of centers to which research programs referred families and centers selected by families independently of the program. Also, in some research programs, many families chose to use family child care homes or informal child care providers such as relatives or friends. The average ITERS scores reported here are based exclusively on observations of center-based care. We are also assessing the quality of family child care homes using the Family Day Care Rating Scale (FDCRS). We will report programs' average FDCRS scores for family child care homes used by early Head Start families in the next implementation report.

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[2] The average ITERS scores provided here do not reflect the average quality of child care received by individual program children. Rather, they represent the average quality of Early Head Start and community child care centers, determined at the classroom level, used by program families. Average scores for each program are not weighted to reflect the number of program children participating in each classroom or center.

III. IMPLEMENTATION OF EARLY CHILDHOOD DEVELOPMENT AND HEALTH SERVICES

The central goal of Early Head Start is to foster children's healthy development during their early years. In the revised Head Start Program Performance Standards, the Head Start Bureau lays out specific program requirements intended to ensure that Early Head Start programs achieve this goal. U.S. Department of Health and Human Services (DHHS) Secretary Donna Shalala's Advisory Committee on Services for Families with Infants and Toddlers, which provided broad guidelines for the new Early Head Start program, identified a commitment to high-quality services, both services provided directly and those provided through referral, as a key program principle. In the Early Head Start grant announcement, the Head Start Bureau requires programs to provide early childhood development and health services that are of high quality (U.S. Department of Health and Human Services 1995). In this chapter, we examine the extent to which the research programs implemented key elements of the revised Head Start Program Performance Standards for providing high-quality early childhood development and health services during their first year of serving families (before the performance standards took effect and before the programs received monitoring visits from the Head Start Bureau). We also examine service quality in one aspect of early childhood development services in more depth by presenting preliminary data from observations of the center-based child care settings used by Early Head Start families in the research sample.

A. IMPLEMENTATION OF EARLY CHILDHOOD DEVELOPMENT AND HEALTH SERVICES

To rate the extent of program implementation in the area of early childhood development and health services, we examined seven aspects of each research program's child development and health services component: (1) developmental assessments, (2) individualization of services to children's and parents' specific needs, (3) parent involvement in child development services, (4) child care, (5) health services for children, (6) frequency with which child development services--whether home-based or center-based--were provided, and (7) group socialization activities for families that receive services through the home-based option.[1] After examining the extent of implementation in each of these specific areas, we produced an implementation rating for each research program's early childhood development and health services component.

About half of the research programs reached full implementation of Early Head Start child development and health services by fall 1997 (Figure III.1). An additional six programs reached a moderate level of implementation, because some aspects of the child development and health services component were not yet fully implemented. Across program options, center-based programs were most likely to be fully implemented; 75 percent of center-based programs, compared with only 25 percent of home-based programs, had reached full implementation. Among mixed-approach programs, 60 percent had reached full implementation.

In fall 1997, the majority of research programs had fully implemented four aspects of child development and health services: (1) developmental assessments, (2) individualization of services, (3) parent involvement in child development services, and (4) group socializations[2] (Figure III.2).

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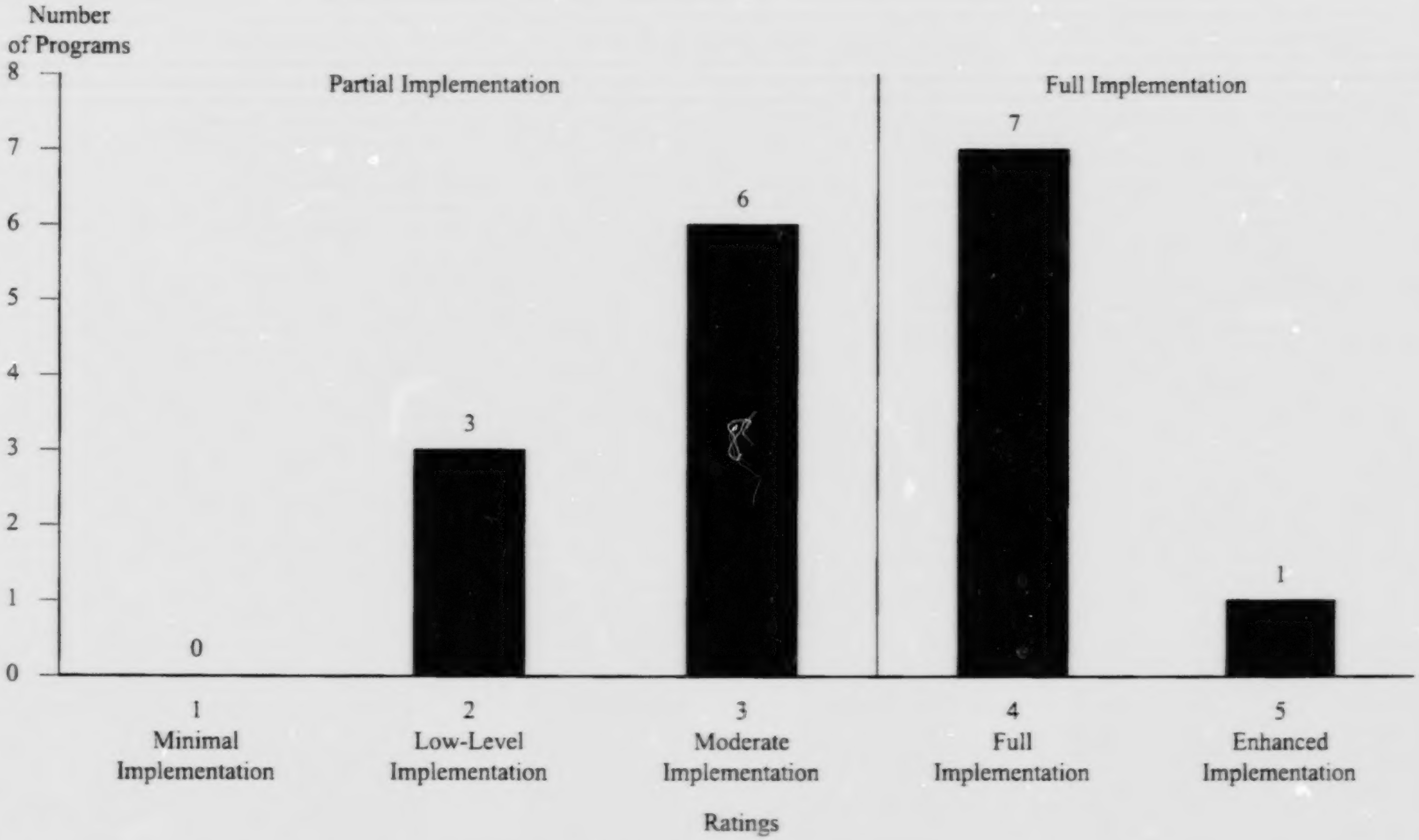
[1] Appendix B contains a detailed description of the rating criteria we developed for each of these dimensions of early childhood development and health services.

[2] We rated programs as fully implemented in the area of group socializations if they offered these activities to families on a regular basis. We did *not* consider the extent of regular participation among families that received home-based services because the revised Head Start Program Performance Standards specified the offer of services; we added participation levels to the scale criteria in 1999.

FIGURE III.1

EARLY HEAD START EARLY CHILDHOOD DEVELOPMENT AND HEALTH SERVICES
IMPLEMENTATION RATINGS
FALL 1997

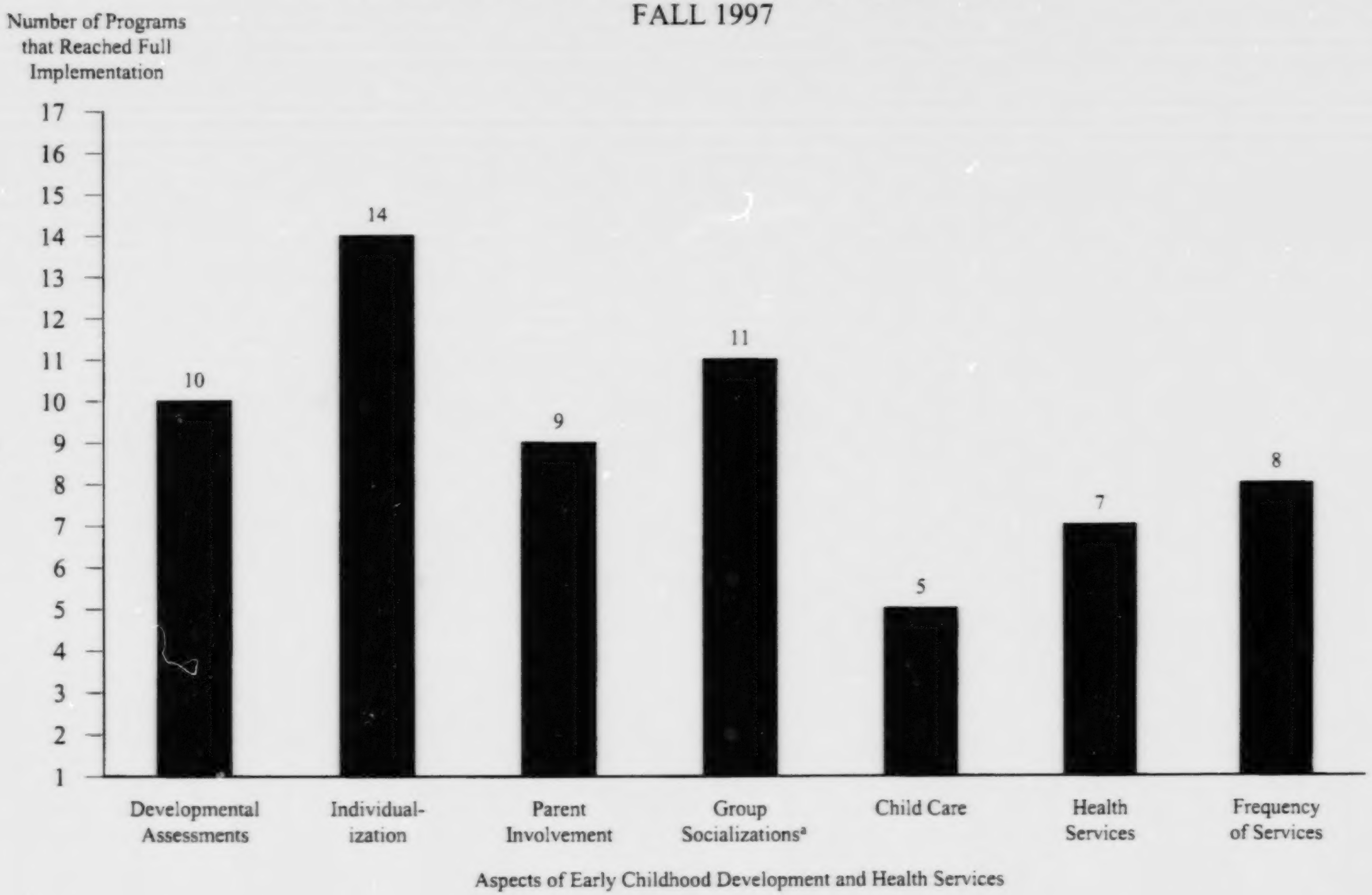


Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

Note: Implementation ratings for early childhood development and health services represent the average rating across all the dimensions we examined. Programs rated as fully implemented achieved full implementation in most of the dimensions we examined, but did not necessarily achieve full implementation in every dimension (see Figure III.2 for a list of dimensions).

FIGURE III.2

EARLY HEAD START EARLY CHILDHOOD DEVELOPMENT AND HEALTH SERVICES: ASPECTS THAT WERE FULLY IMPLEMENTED BY FALL 1997



Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

[a] We rated programs as reaching full implementation in this area if they offered the group socialization activities required by the revised Head Start Program Performance Standards. This rating is based on the offer of services, rather than the number of families that participated regularly.

Other elements of early childhood development and health services--child care, health services for children, and frequency of child development services--presented greater challenges in the early stages of program implementation.

1. Developmental Assessments

The revised Head Start Program Performance Standards require programs to conduct developmental assessments that evaluate children's motor, language, social, cognitive, perceptual, and emotional skills. Furthermore, the standards encourage programs to conduct these assessments in collaboration with parents and in a manner that is sensitive to children's cultural backgrounds. When assessments indicate a potential disability or delay, programs must refer families to an early intervention (Part C) service provider and support families' participation in these services. We rated programs as fully implemented if they conducted or arranged for periodic developmental assessments and coordinated closely with Part C providers to make referrals and provide services to families and children.

In fall 1997, 10 of the 17 research programs had fully implemented a strategy for conducting developmental assessments and coordinating with Part C providers. These programs conducted or arranged for regular developmental assessments with all or almost all enrolled children. Research programs used a variety of screening and assessment tools, including the *Ages & Stages Questionnaires*, the *Denver Developmental Screening Test II*, the *Early Learning Accomplishment Profile*, and the *Hawaii Early Learning Profile*. These programs involved parents in the evaluation process by encouraging them to be present during the assessment, by helping them to participate directly in the assessment (for example, by completing the *Ages & Stages Questionnaires*), and by discussing with them the results of the assessment and activities recommended to strengthen weak areas. Some programs referred children to early intervention programs or other agencies for further assessment if they suspected a disability or delay, and some programs conducted additional assessments themselves before making a referral. Nevertheless, all of these programs referred children with suspected disabilities to a Part C service provider and worked closely with families throughout the Part C assessment and service planning process. They also collaborated closely with Part C providers to coordinate services for the family and child, and in some cases they worked together with the Part C provider to develop joint service plans for the family.

Seven research programs had only partially implemented developmental assessments and appropriate referrals by fall 1997. Some of these programs had not yet conducted developmental assessments with some enrolled children. In other cases, programs referred children to Part C providers when staff suspected a delay or disability, but they did not coordinate Early Head Start services with the Part C provider.

2. Individualization of Services

To ensure that services are individualized to children's distinct rates of development and backgrounds, the revised Head Start Program Performance Standards require programs to implement an approach to child development that respects children's individual rates of development, temperament, gender, culture, language, ethnicity, and family composition. Fourteen of the 17 research programs had fully implemented a strategy for individualizing child development services in fall 1997. Almost all families enrolled in these programs received child development services in the language they spoke at home, usually English or Spanish. In addition, these programs provided child development services to families according to their individual needs, taking into account the child's developmental progress, the family's cultural background, and other aspects of the family's circumstances.

Research programs used a variety of methods for individualizing services according to need. For example, several programs used the results of developmental assessments to plan future child development services and activities. Programs also responded to needs expressed directly by parents. Many programs focused their parent education activities and, to some extent their child development activities with children, on concerns raised by parents about specific developmental issues such as motor skills, language, or sleeping patterns. Finally, these programs planned their home-based and center-based child development activities to accommodate children's special needs for physical care, equipment, or early intervention services.

3. Parent Involvement in Child Development Services

According to the revised Head Start Program Performance Standards, programs should involve parents in child development services by encouraging their involvement in planning the program's child development curriculum and approach, helping parents to improve their child observation skills, and discussing children's development with parents during staff-parent conferences and home visits. Nine research programs had fully implemented these parent involvement requirements by fall 1997. These programs involved parents in the planning and delivery of child development services through a variety of methods. For instance, several programs involved parents directly in conducting developmental assessments, especially those using the *Ages and Stages Questionnaires*, and then worked with parents to plan services to address any potential weaknesses identified. Many parents participated in planning activities and parent education topics for child development home visits. Center-based programs involved parents by forming Parent Committees to help design the center's program and by encouraging parents to volunteer in center classrooms.

4. Group Socialization Activities

The revised Head Start Program Performance Standards require programs to provide two group socialization activities per month for families that receive services through the home-based option. We rated research programs as fully implemented if they offered these activities to families on a regular basis, regardless of participation rates. Of the 13 research programs offering home-based services, 11 invited families to attend regular group socialization activities in fall 1997. The frequency of group socialization activities offered by these programs ranged from weekly to monthly. All of these programs offered at least two hours of group socialization activities per month; a few programs offered as many as eight hours per month. Types of group activities for parents and children included play groups, food festivals, picnics, outings, special events on particular themes, and parent-child events that focused on a variety of health and development topics.

While these programs offered regular group socialization activities to all families, many programs reported that attendance at these activities was fairly low. In fact, only two research programs were able to achieve regular participation by half or more of the families receiving home-based services. Program staff cited parents' work schedules and other demands on parents' time as barriers that prevented some families from attending. In addition, some parents were reluctant to socialize and get involved in these events. Several programs found that it took a while for some parents to feel comfortable in group activities.

5. Child Care

Whether Early Head Start programs provide child care directly or broker child care services in the community, they are responsible for ensuring that the child care settings meet the revised Head Start Program Performance Standards. For example, the standards require group care settings for infants and toddlers to maintain child-caregiver ratios of 4 to 1 or less and group sizes of 8 or fewer children (U.S. Department of Health and Human Services 1996). Since fall 1997, the Head Start Bureau has given programs further guidance about their responsibilities for brokering child care services in the community. Programs must ensure that community child care settings meet the standards for group care established in the revised Head Start Program Performance Standards and should ideally establish agreements with child care providers that require adherence to these standards. Because this additional guidance had not been clarified at the time of our fall 1997 site visits, we did not incorporate these requirements for agreements to adhere to the performance standards in community child care settings into the implementation rating scales we used. We rated research programs as fully implemented if they either provided child care directly or brokered community child care services for all families that needed it, assessed the quality of community child care settings before making referrals, and monitored child care settings regularly to ensure that they met standards for high quality.

In the early stages of implementation, research programs experienced difficulty meeting the Head Start Bureau's child care requirements, as defined in our implementation rating scale. Only five of the research programs had fully implemented their child care components in fall 1997.[3] Of these, three were mixed-approach programs, one was a home-based program, and one was a center-based program. These programs either provided child care directly or helped families arrange child care. If they helped families arrange child care, they systematically assessed the quality of care before making placements, regularly monitored the quality of child care arrangements after placements were made, and provided training and support to child care providers caring for Early Head Start children. The mixed-approach programs served some families that needed child care through the center-based option and some families through the home-based option. In the latter case, they monitored the quality of community child care that families used. In addition, some mixed-approach programs offered some families both of these services. The home-based program offered home-based services, but it was also actively involved in arranging and supporting high-quality child care arrangements for families that needed them. The center-based program offered high-quality child care that met the performance standards to almost all families that needed child care.

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[3] Because this volume focuses on implementation, readers may wish to consult Volume I for greater detail about the nature of child care services in different program designs.

Three additional research programs (two center-based and one mixed-approach) achieved moderate levels of implementation of child care services in fall 1997. Each of these programs provided child care that met the performance standards to some families directly, and two also assessed the quality of other child care arrangements prior to making referrals. However, these programs were either unsuccessful in finding high-quality arrangements for families that needed community child care outside program hours, or they did not conduct ongoing monitoring and training with all providers to whom they referred families.[4]

In nine research programs, staff provided only limited help to families that needed child care, and programs had not yet reached moderate or full implementation in this area. Seven of these were home-based programs, one was a mixed-approach program, and one was a center-based program.[5] Most of these programs either provided some child care directly or referred families that needed child care to individual providers or local resource and referral agencies, but they did not systematically assess, monitor, and support the quality of community child care arrangements used by Early Head Start families.

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[4] In one center-based program, the grantee offered non-Early Head Start child care outside of program hours, but the child care subsidies that were available to pay for the care were not sufficient for maintaining the ratios and group sizes maintained in the Early Head Start program. In another center-based program, one center had not yet opened in fall 1997, and program staff referred families that needed child care to the local resource and referral agency but did not monitor the quality of the arrangements that families used.

[5] The center-based program was providing part-time child care in fall 1997 and did not help families that needed additional child care find arrangements or monitor the quality of their arrangements.

6. Health Services for Children

The revised Head Start Program Performance Standards require programs to ensure that all children have a regular health care provider and access to needed health, dental, and mental health services. In addition, programs must keep track of health services provided to ensure that children receive all recommended well-child examinations, immunizations, and treatment for identified conditions.

Seven research programs had fully implemented Early Head Start child health services in fall 1997. Fourteen research programs worked with families to ensure that children had medical homes or primary care physicians, and many of these programs helped parents and children obtain needed dental and mental health services as well. Fewer research programs, however, had implemented tracking and follow-up procedures to ensure that children received well-child visits, immunizations, and treatment for illnesses according to recommended schedules.

Seven research programs made some effort to follow up on health services, but only four of them had implemented procedures to ensure systematic tracking and followup for every child. Several of these programs used databases to record and track immunizations and other health services received by enrolled children. Typically, programs that used systematic tracking procedures asked parents to sign consent forms permitting program staff to contact their health care providers to obtain the medical records necessary for tracking. Across all research programs, center-based and mixed-approach programs were more likely than home-based programs to implement these systematic tracking procedures. Because center licensing standards require participating children to have up-to-date immunizations, programs providing center-based services were perhaps more likely to implement the tracking procedures necessary for ensuring compliance with state licensing requirements.

7. Frequency of Child Development Services

The revised Head Start Program Performance Standards contain specific requirements for the center-based and home-based options about the frequency with which child development services must be provided. Center-based programs must provide at least half-day services, and home-visiting programs must provide weekly, 90-minute home visits, completing at least 48 home visits per year. Mixed-approach programs must provide either a prespecified combination of center-based and home-based services or center-based services to some families and home-based services to others. Because we were not able to systematically review program attendance and home-visiting records, we simplified these requirements and rated research programs as fully implemented if almost all children received child development services at least two times per month and almost all parents received parent education services at least once per month. We considered children to have received child development services at least two times per month if they participated in two child development home visits per month or attended an Early Head Start child care center. While the performance standards clearly require programs to complete at least four child development home visits per month, the rating panel chose two completed child development home visits per month with almost all families as the minimum requirement for full implementation at this initial stage of program development. At the time, this seemed justified because of multiple services connected with home visits and lack of clarity with respect to criteria for combining other services with home visits.[6]

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[6] For the final round of implementation ratings, based on program information collected in fall 1999, we revised our definitions for full and enhanced implementation in this area to more accurately (continued...)

Eight research programs had achieved this level of service frequency in fall 1997, including five home-based programs, two center-based programs, and one mixed-approach program. Although 6 of the 13 research programs providing services through the home-based option completed at least two child development home visits per month with almost all families, almost all home-based programs faced challenges in trying to complete the number of child development home visits required by the performance standards (at least four per month). Parents or home visitors sometimes canceled home visits due to illness or scheduling conflicts and found it difficult to reschedule and make up missed visits within the same week. In some locations, weather conditions sometimes prevented program staff from traveling to families' homes. Moreover, in the wake of welfare reform, many parents began working during the day, making it more difficult for staff members to complete child development home visits during traditional working hours. While some programs attempted to conduct evening home visits, many found that parents and children were often too tired and busy preparing for the next day's activities to focus on child development activities. Finally, some programs reported facing challenges in trying to complete planned child development activities during home visits, because parents placed greater emphasis on family development needs.

Programs implementing the center-based option faced a different set of challenges in providing child development services. Because most children attended the centers on a daily basis, these programs were able to provide regular child development services to children. Several center-based and mixed-approach programs, however, faced challenges to providing regular parent education to all parents. Because these programs did not conduct child development home visits for children

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[6](...continued)
reflect the performance standards. We rated research programs as fully implemented if almost all children received child development services at least three times a month and parents received parent education at least monthly. Programs' levels of implementation were rated as enhanced when almost all children received child development services at least four times per month and parents received parent education at least monthly.

receiving full-time center-based care, in some programs the staff found it challenging to arrange group or individual meetings with parents to provide parent education. For example, parents' work schedules sometimes interfered with staff members' ability to meet with parents individually or to schedule group parent education workshops during the day. At the same time, research programs sometimes found it difficult to achieve good attendance levels at evening parent meetings and parent education sessions. Working parents faced many demands on their time, and attending evening parent education meetings was not always a high priority. Logistic problems, such as lack of child care or transportation, sometimes posed barriers to parents' attendance at evening meetings.

B. OBSERVATIONS OF QUALITY IN CENTER-BASED CHILD CARE SETTINGS

The Head Start Bureau requires that programs either provide child care directly or broker child care services in the community for all families that need it, and that programs take steps to ensure that child care used by Early Head Start families meets the revised Head Start Program Performance Standards. As described in Chapter II, we conducted observations of the center-based child care settings Early Head Start families used when their children were 14 and 24 months old and employed the Infant/Toddler Environment Rating Scale (ITERS) to assess the level of quality of these settings. This section describes preliminary data from observations of center-based child care provided directly by Early Head Start research programs and observations of Early Head Start children's classrooms in community child care centers.

1. Child Care Quality in Early Head Start Centers

Nine of the 17 research programs provided center-based child care directly to some or all families. These services were almost always full-time, were based on a variety of curriculum resources, and according to staff reports during site visits, were usually provided to infants and toddlers with relatively small child-staff ratios (4 to 1 or smaller) and often in small group sizes (8 or fewer children), as required by the revised Head Start Program Performance Standards (Figures III.3 and III.4). These ratios and group sizes are generally associated with more positive child outcomes.

The preliminary ITERS data suggest that on average, the quality of center-based child care provided by the nine center-based and mixed-approach research programs during their first two years of serving families was good (5.4).[7] The average quality of care observed in these Early Head Start centers was well above minimal (above 4) in all nine research programs that provided center-based care (Figure III.5). These preliminary findings are consistent with findings of the *Head Start Family and Child Experiences Survey (FACES)*, which found that the average quality of center-based care provided by Head Start programs was good (Early Childhood Environment Rating Scale [ECERS] score of 4.9) (U.S. Department of Health and Human Services 1998).

Although the average quality of center-based child care was good in all of the research programs, it varied across Early Head Start programs from the lower end of the good range to excellent. Average program ITERS scores ranged from 4.1 to 6.3. In five programs, the average

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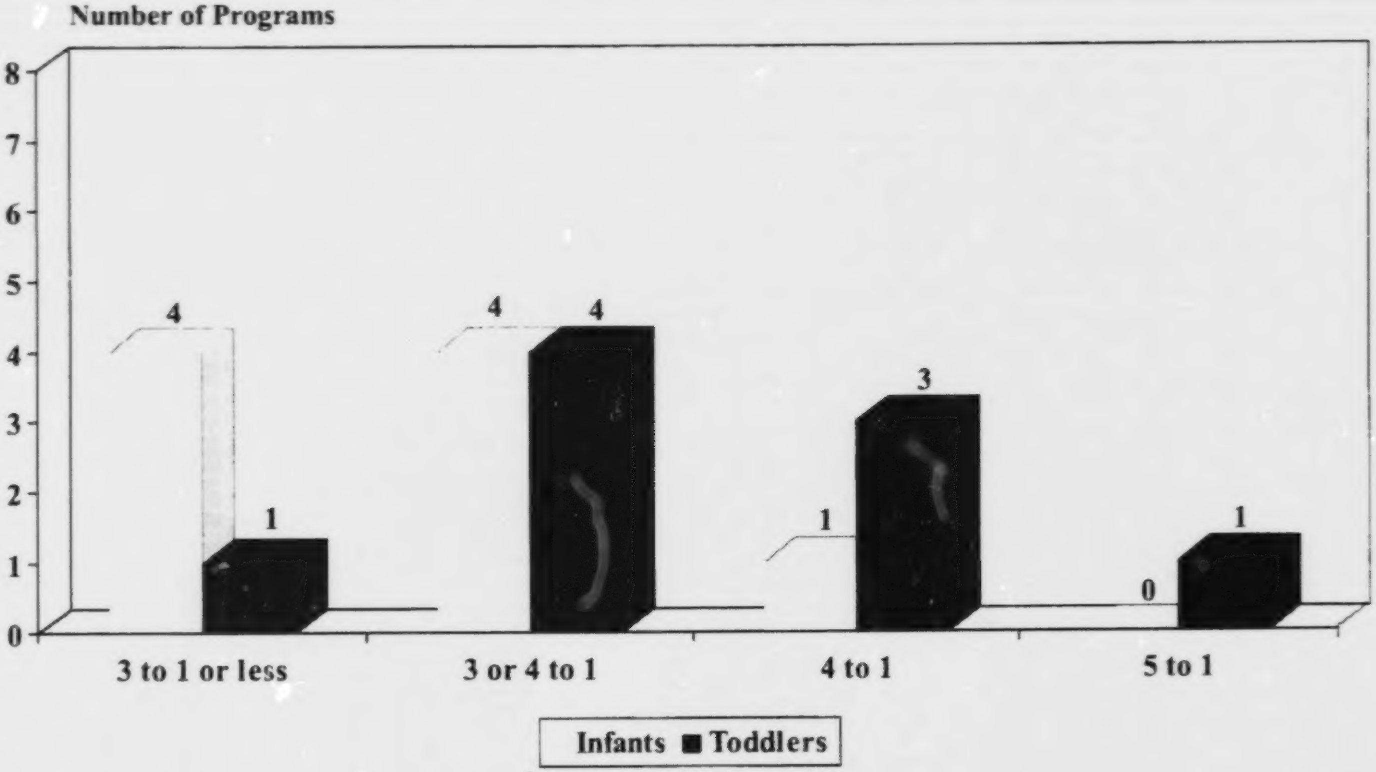
[7] Average scores of 5.0 and above on the 7-point ITERS scale are generally interpreted as good to excellent quality. Scores of 3.0 to 5.0 are considered minimal to good quality, and scores of 1.0 to 3.0 are considered inadequate quality.

FIGURE III.3

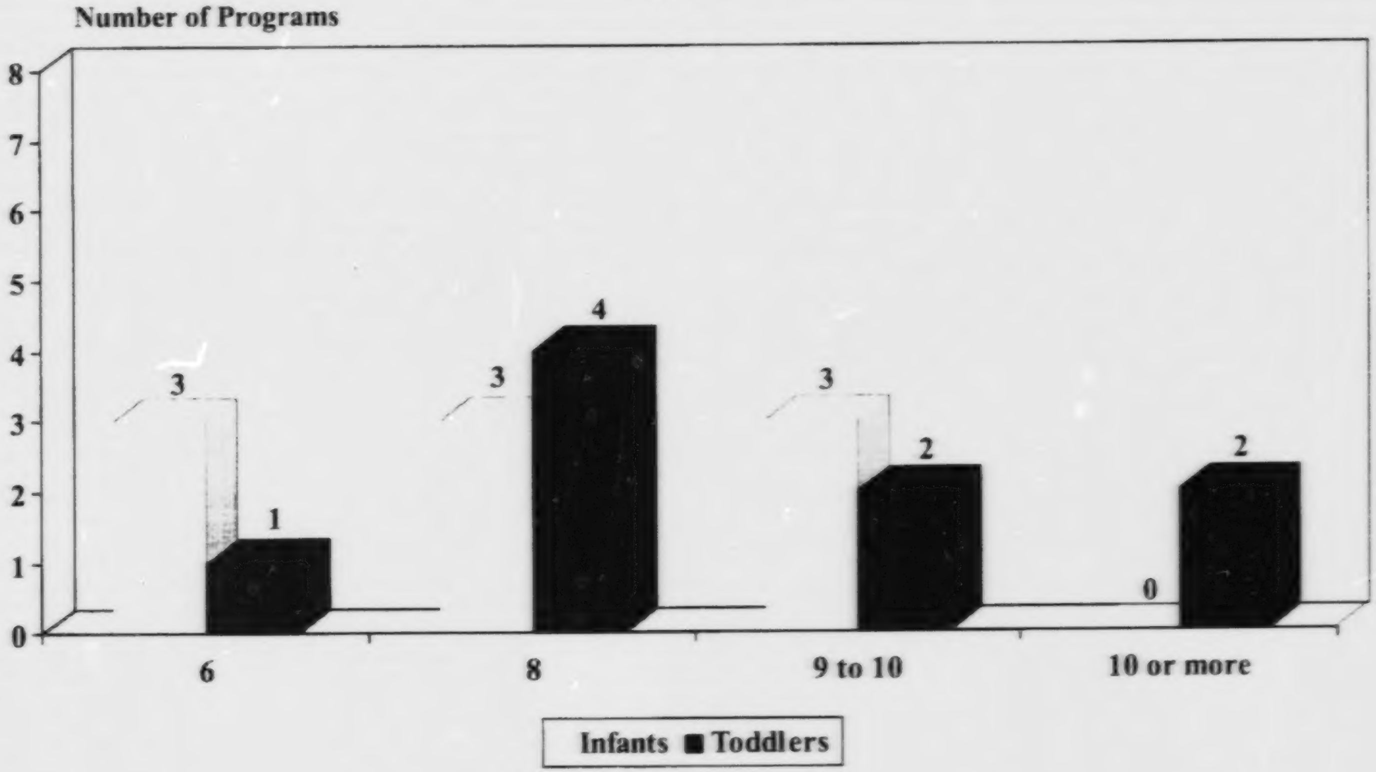
PLANNED CHILD-CAREGIVER RATIOS IN EARLY HEAD START CENTERS, FALL 1997
(As Reported by Staff)



Note: These data were collected in fall 1997, prior to the enactment of the revised Head Start Program Performance Standards and before Head Start Bureau staff conducted monitoring visits. The ratios reported in this figure were reported by programs and were *not* observed during child care quality assessments.

FIGURE III.4

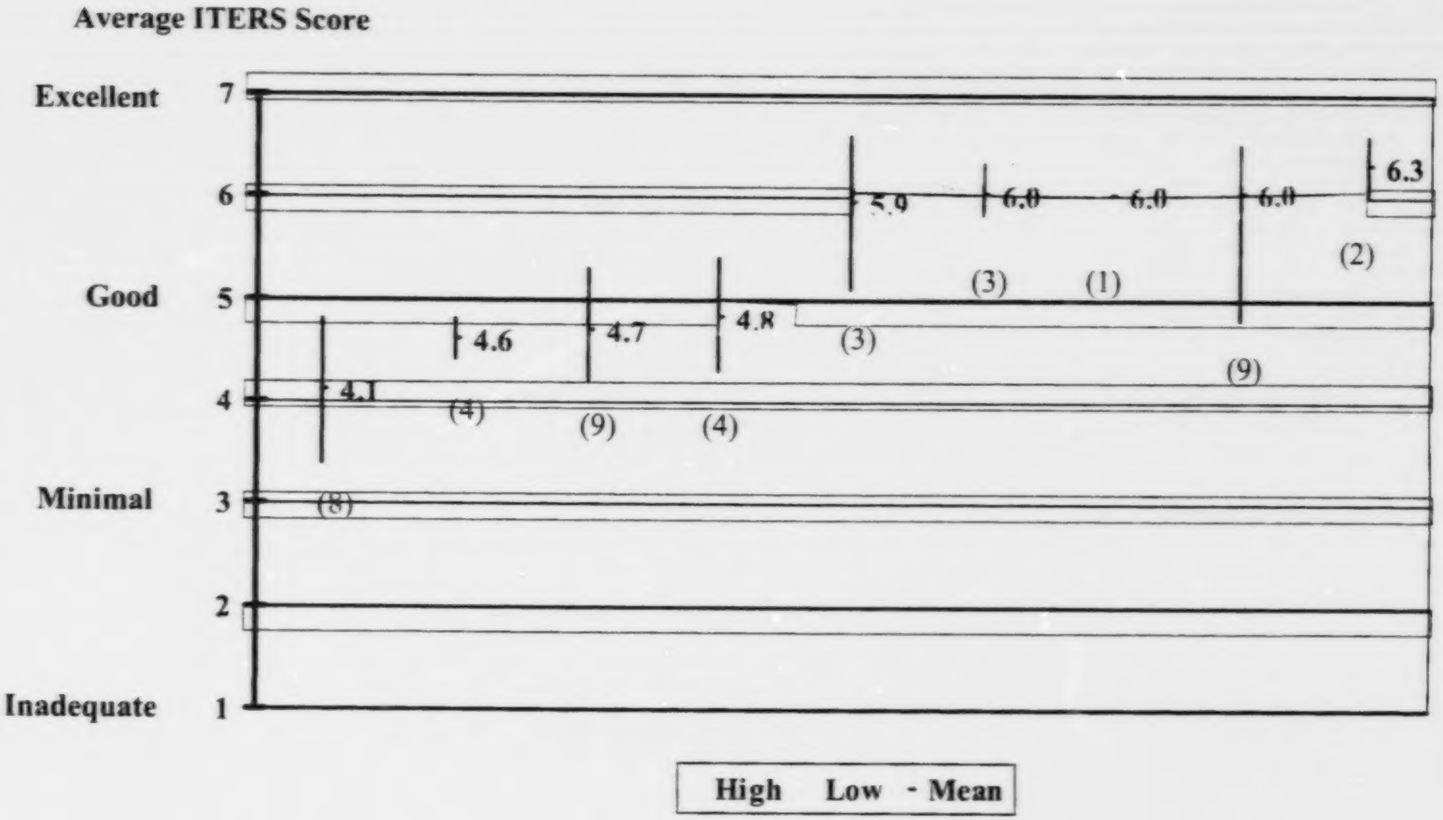
PLANNED GROUP SIZES IN EARLY HEAD START CENTERS, FALL 1997
(As Reported by Staff)



Note: These data were collected in fall 1997, prior to the enactment of the revised Head Start Program Performance Standards and before Head Start Bureau staff conducted monitoring visits. The group sizes reported in this figure were reported by programs and were *not* observed during child care quality assessments.

FIGURE III.5

CHILD CARE QUALITY IN EARLY HEAD START CENTERS



Note: Based on 162 classroom observations in 9 programs conducted in 1997 and 1998. The numbers in parentheses represent the number of classrooms observed at each research program.

ITERS = Infant/Toddler Environment Rating Scale.

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ITERS score was 5.9 or higher, indicating that the quality of care observed was in the good-to-excellent range.

Early Head Start centers tended to receive the highest scores in the personal care routines, interactions, and program structure categories of the ITERS and the lowest scores in the adult needs, learning activities, and furnishings categories. The strength in the personal care routines and interactions categories may reflect the strong emphasis in the performance standards on safety and child-teacher interactions and relationships.

The quality of care in Early Head Start centers also varied across classrooms within programs. In three programs the minimum and maximum ITERS scores were more than one level apart, while in six programs the minimum and maximum ITERS scores were within one level of each other (Figure III.5). No ITERS scores for Early Head Start centers, however, fell below the minimal-to-good range.

The good quality of center-based care provided by the Early Head Start research programs stands out in contrast to the poorer quality of center-based care provided to infants and toddlers in many community centers across the nation. *The Cost, Quality, and Outcomes Study* found that infant/toddler classrooms in two-thirds of centers in the five study sites did not provide good-quality care (that is, received ITERS scores under 4) (Cost, Quality, and Outcomes Study Team 1995). Observational data from the *National Child Care Staffing Study* also showed that a significant proportion of centers provided poor-quality infant and toddler care. Although teacher characteristics and global indexes of child care quality did not differ significantly between centers serving predominantly low-income children and those serving high-income children, teacher sensitivity was significantly lower and detachment significantly more common in low-income than in middle- or upper-income centers (Phillips, Voran, Kisker, Howes, and Whitebook 1994).

2. Child Care Quality in Community Child Care Centers Used by Early Head Start Families

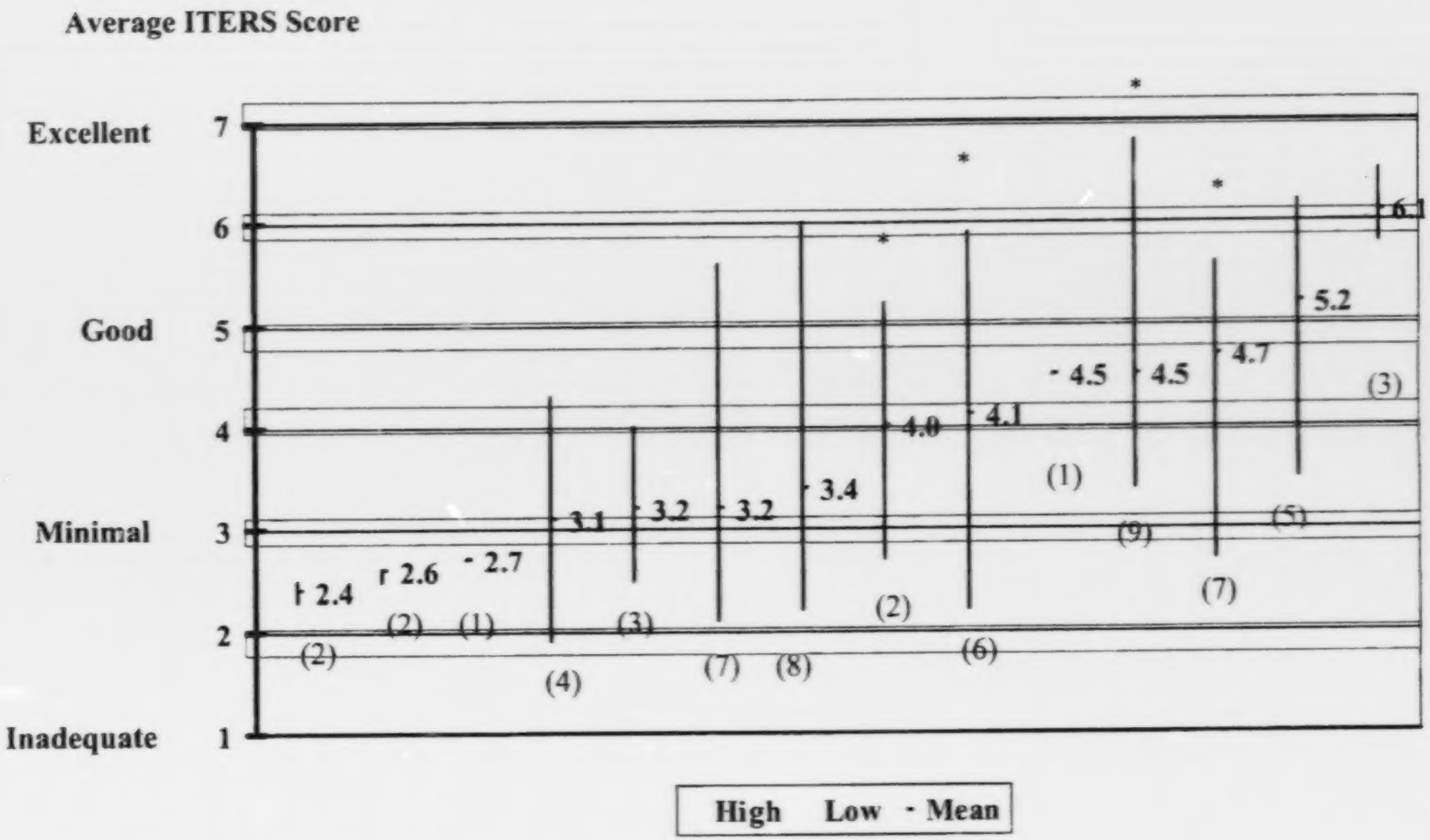
Many parents of children in the Early Head Start research programs sought child care in their communities. In some cases program staff helped them find child care, and in other cases the families found it on their own.

Based on early observations in community child care centers used by Early Head Start families in the research sample when children were 14 and 24 months old, and irrespective of whether programs were assessing, monitoring, or seeking to improve the quality of community child care, the average quality of child care provided to Early Head Start children by community centers ranged from minimal to excellent. Across the 14 research programs where observation data have been collected in community child care centers used by program families, the average ITERS score was 3.8 (in the minimal-to-good range) (Figure III.6). Average ITERS scores ranged from 2.4 (less than minimal) to 6.1 (good-to-excellent) across classrooms in community child care centers where Early Head Start children were receiving care. In six research programs, community child care centers caring for Early Head Start children provided care that was, on average, of good or excellent quality (ITERS scores above 4).

The research programs where community child care centers used by Early Head Start families provided the highest quality care, on average, were programs that provided home-based services. The average ITERS score for child care centers in communities where home-based research

FIGURE III.6

CHILD CARE QUALITY IN COMMUNITY CENTERS



Note: Based on 79 classroom observations in 14 programs sites--in 1997 and 1998. The numbers in parentheses represent the number of community child care centers observed at each research program.

ITERS = Infant/Toddler Environment Rating Scale.

* Early Head Start program assessed and/or monitored care.

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programs are located was 4.1, ranging from 2.4 to 6.1 (Figure III.7). ITERS scores ranged from 2.7 to 4.0, with an average score of 3.3, in communities where center-based research programs are located (Figure III.8).[8] In communities with mixed-approach research programs the average ITERS score was 3.8, ranging from 2.6 to 4.7 (Figure III.9).

The quality of care observed in community child care centers used by Early Head Start families was highly variable. In most research programs with more than three classroom observations in community child care centers, the minimum and maximum ITERS scores differed by more than two levels. This wide variation may reflect the variation in the quality of the available center-based child care in the community. It is notable that the ITERS scores in center-based community child care settings were more variable than the scores in the Early Head Start centers, which were more consistently good.

The average ITERS scores for classrooms in community settings were in the minimal-to-good range (ranging from 4.0 to 4.7) for all research programs that were assessing and/or monitoring the quality of child care that enrolled children received in community settings.[9] Some ITERS scores for community child care centers used by children in those programs, however, fell below the good range, possibly reflecting the fact that some families chose child care arrangements independently of the Early Head Start program.

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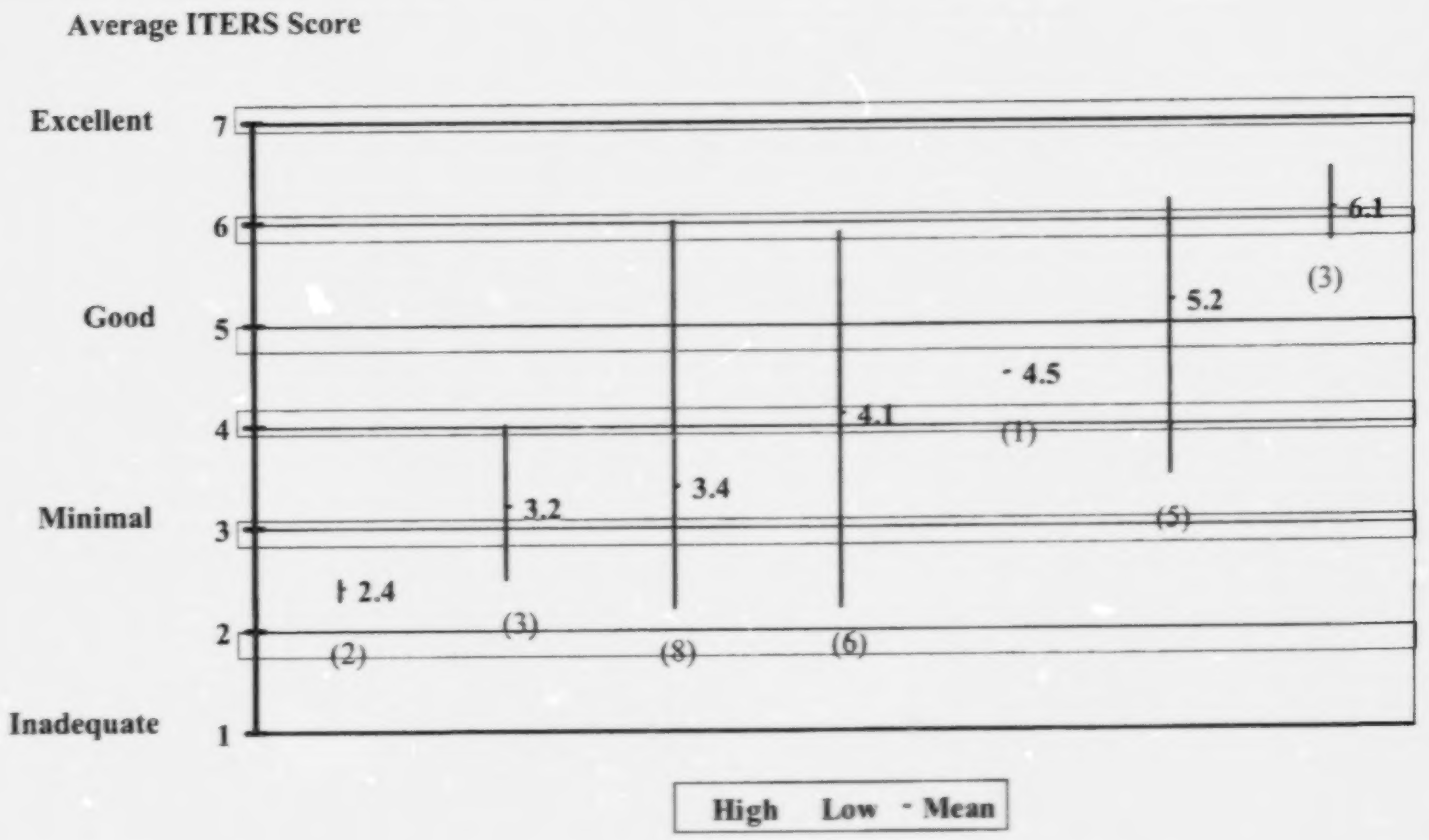
[8] Small numbers of children in center-based research programs had other (non-Early Head Start) primary child care arrangements, or they were being cared for in a community center while construction of the Early Head Start center was completed.

[9] As noted earlier, the Head Start Bureau's expectation that programs are responsible for ensuring all community child care settings used by Early Head Start families adhere to the revised Head Start Program Performance Standards for center-based services was not initially clear to all research programs. Some did not begin taking steps to ensure that child care quality adhered to the performance standards until after Head Start Bureau monitoring visits that occurred in spring 1998.

FIGURE III.7

CHILD CARE QUALITY IN COMMUNITY CENTERS
(Home-Based EHS Programs)



Note: Based on 40 classroom observations in 28 centers across 7 Early Head Start research sites conducted in 1997 and 1998. The numbers in parentheses represent the number of community child care centers observed at each research program.

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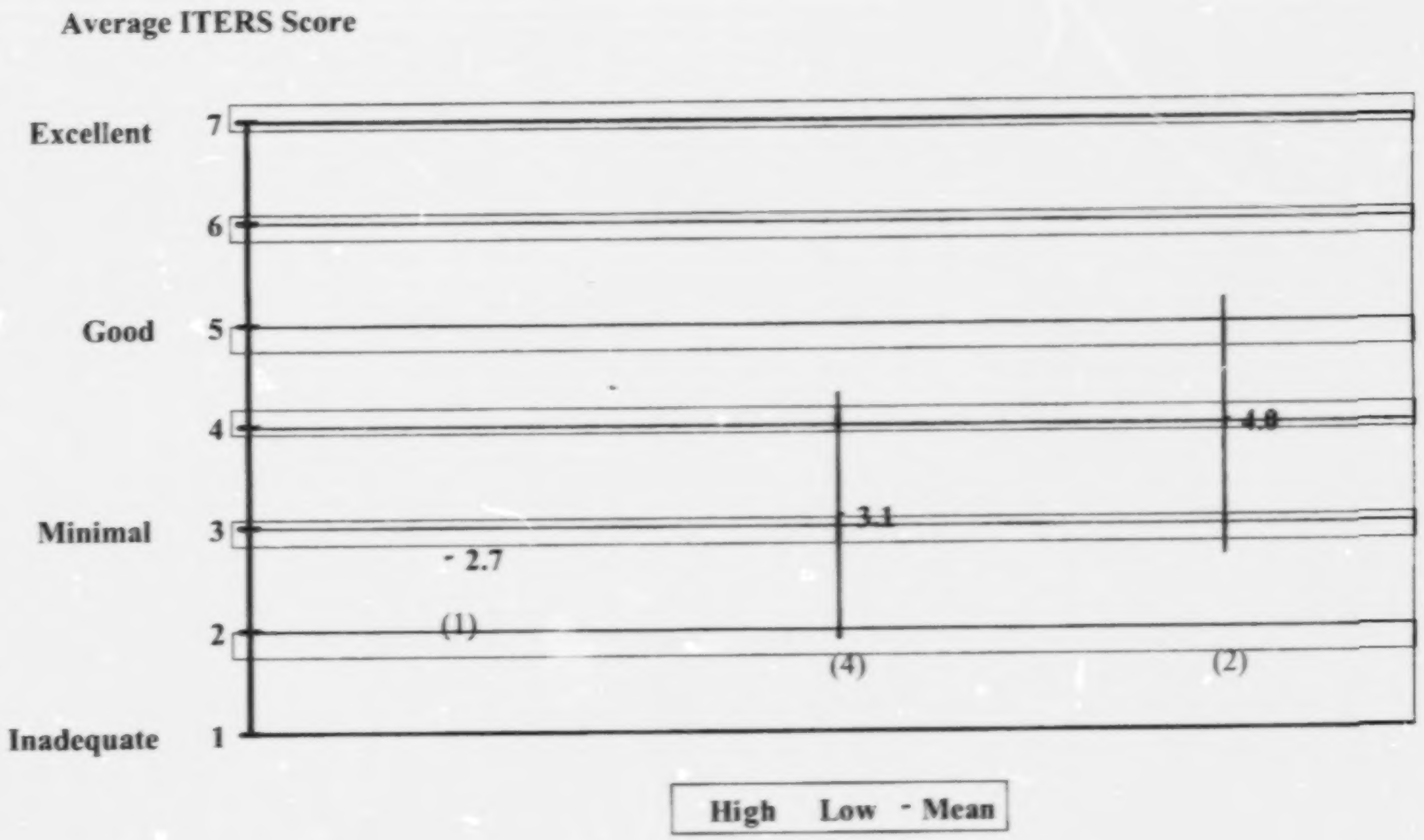
FIGURE III.8

CHILD CARE QUALITY IN COMMUNITY CENTERS
(Center-Based EHS Programs)



Note: Based on nine classroom observations in seven community centers across three Early Head Start research sites. The numbers in parentheses represent the number of community child care centers observed at each research program site.

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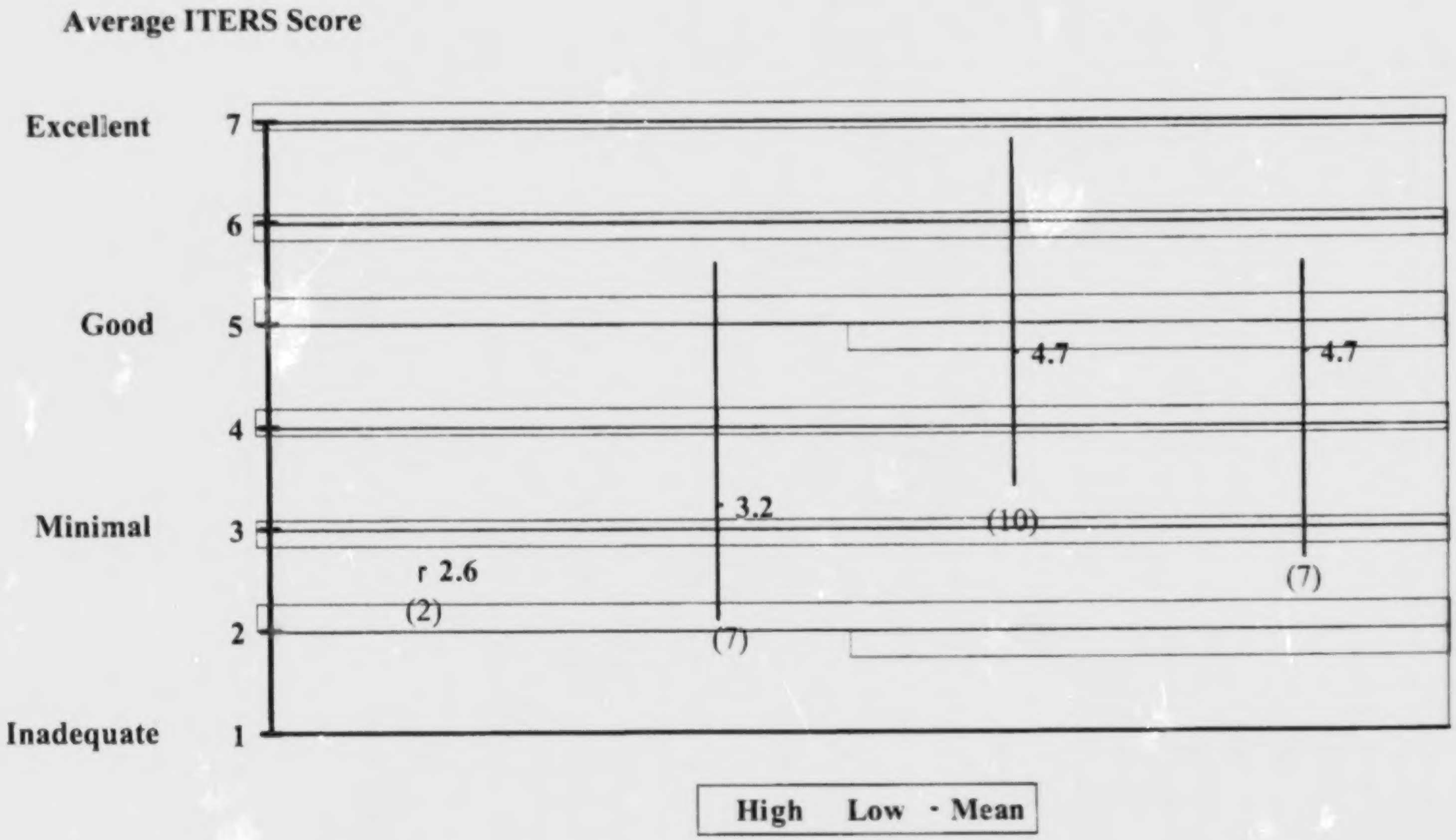
FIGURE III.9

CHILD CARE QUALITY IN COMMUNITY CENTERS
(Mixed-Approach EHS Programs)



Note: Based on 31 classroom observations in 26 centers across 4 Early Head Start research sites. The numbers in parentheses represent the number of community child care centers observed at each research program site.

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Community child care centers used by Early Head Start families tended to receive the highest scores in the interactions and program structure categories of the ITERS and the lowest scores for the adult needs, learning activities, and furnishings categories. Although the scores are higher for the Early Head Start centers, the relative differences among ITERS categories are consistent across Early Head Start centers and community centers and suggest that obtaining adequate materials and implementing the full range of activities assessed in the ITERS is especially challenging.

IV. FAMILY AND COMMUNITY PARTNERSHIPS

Children develop within families, and families develop within communities. Therefore, the revised Head Start Program Performance Standards require programs to engage families and communities as partners in supporting young children's healthy development. Programs must develop partnerships with families that support their efforts to nurture their children and to meet other critical economic and social needs. Likewise, programs must develop partnerships with other community service providers to promote collaboration and coordination of services for families and to increase families' access to high-quality community services. In this chapter, we examine the extent to which the research programs implemented key elements of the performance standards for developing family and community partnerships.

A. FAMILY PARTNERSHIPS

Because children develop in the context of families, Early Head Start is designed to promote healthy development of families and to foster their self-sufficiency. In support of this goal, the revised Head Start Program Performance Standards require programs to develop individual service plans in partnership with families, provide or arrange for the services that families need, and involve parents in planning and carrying out Early Head Start program activities. To rate the extent of implementation of family partnerships, we reviewed five aspects of each research program's family partnerships component: (1) development of individualized family partnership agreements, (2) availability of services, (3) frequency of services, (4) efforts to promote parent involvement in policymaking and program operations[1], and (5) implementation of father initiatives.[2] We examined the extent of implementation in each of these areas and then assigned an overall implementation rating to each research program's family partnership component.

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[1] In Chapter III, we reported ratings of parent involvement in child development activities, which refers to parents' involvement in planning and delivering child development services (see pages 27-
(continued...)

More than half of the research programs had reached full implementation of Early Head Start's family partnerships component by fall 1997 (Figure IV.1). Six additional research programs had achieved moderate levels of implementation, because some aspects of their family partnerships component were not fully implemented. Across program models, home-based programs were most likely to achieve full implementation in the area of family partnerships. Slightly more than 60 percent of home-based programs had fully implemented their family partnerships component in fall 1997, compared with 50 percent of center-based programs and 40 percent of mixed-approach programs.

1. Individual Family Partnership Agreements

The revised Head Start Program Performance Standards require programs to develop individualized family partnership agreements in collaboration with families. The agreements must identify family goals, specify timetables and strategies for achieving goals, and specify the roles and responsibilities of staff and family members. In addition, to avoid duplication of effort, the standards

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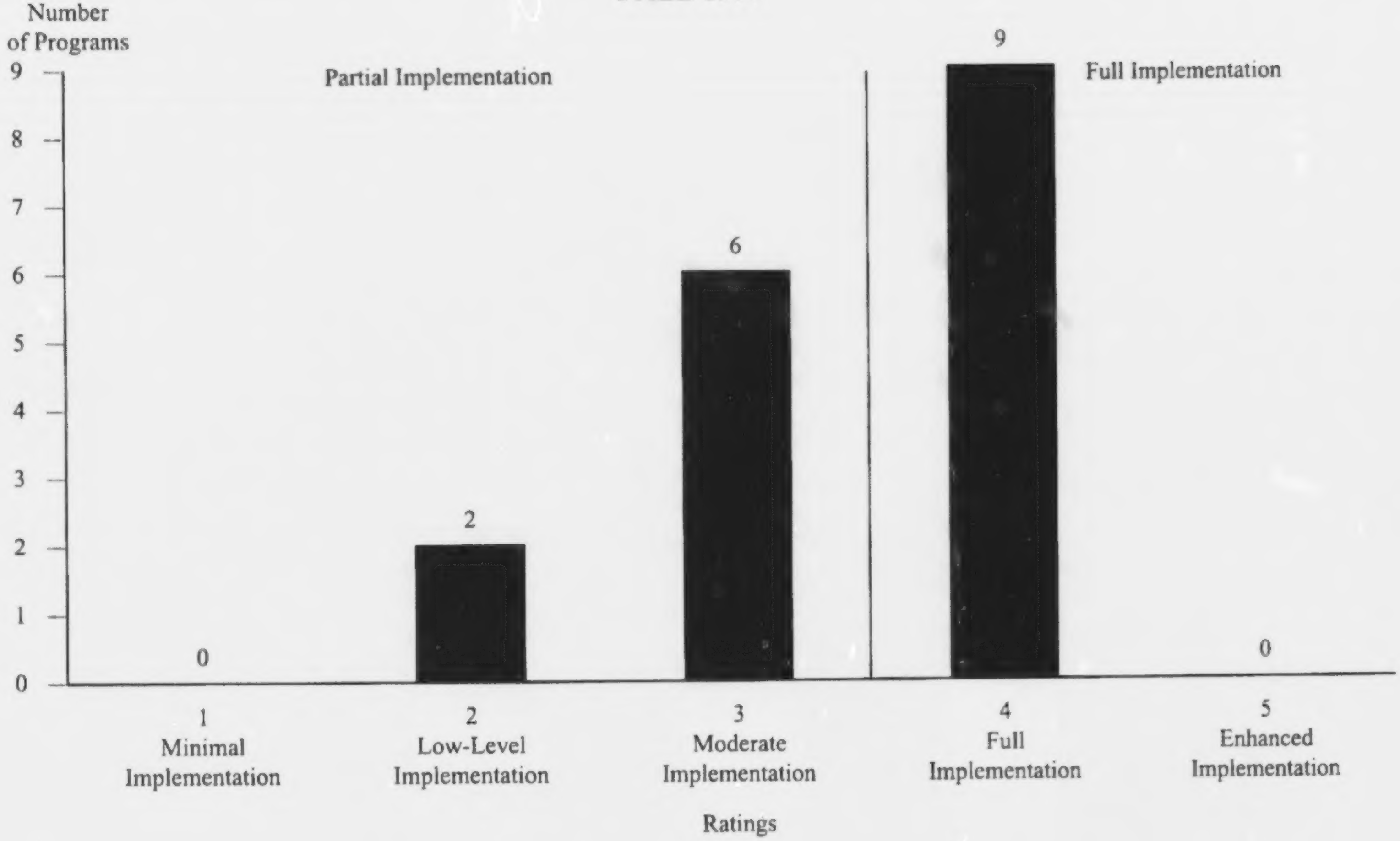
[1](...continued)
28). In this section, parent involvement refers to parents' involvement in program policymaking, operations, and governance. These activities may include child development and other components of the Early Head Start program.

[2] Appendix B contains a detailed description of the rating criteria we developed for each of these dimensions of family partnership services.

FIGURE IV.1

EARLY HEAD START FAMILY PARTNERSHIPS
IMPLEMENTATION RATINGS
FALL 1997



Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

Note: Implementation ratings for family partnerships represent the average rating across all the dimensions we examined. Programs rated as fully implemented achieved full implementation in most of the dimensions we examined, but did not necessarily achieve full implementation in every dimension (see Figure IV.2 for a list of dimensions).

encourage programs to build on existing plans developed by other service providers and to develop joint plans with other service providers when feasible.

Eight research programs had fully implemented these requirements for developing individualized family partnership agreements in fall 1997 (Figure IV.2). Fully implemented research programs had developed family partnership agreements with almost all families in their caseloads, held case management meetings with parents at least once a month, and reviewed and updated the agreements with families on a regular basis. Four of the eight fully implemented research programs also developed joint service plans with other service providers when appropriate, most often with Part C providers.

Nine research programs had partially implemented the requirements for individual family partnership agreements in fall 1997. Of these, five had not yet completed agreements with some families. Four had not provided case management to some families on a monthly basis, and one did not yet have standard procedures in place for developing and updating the agreements.

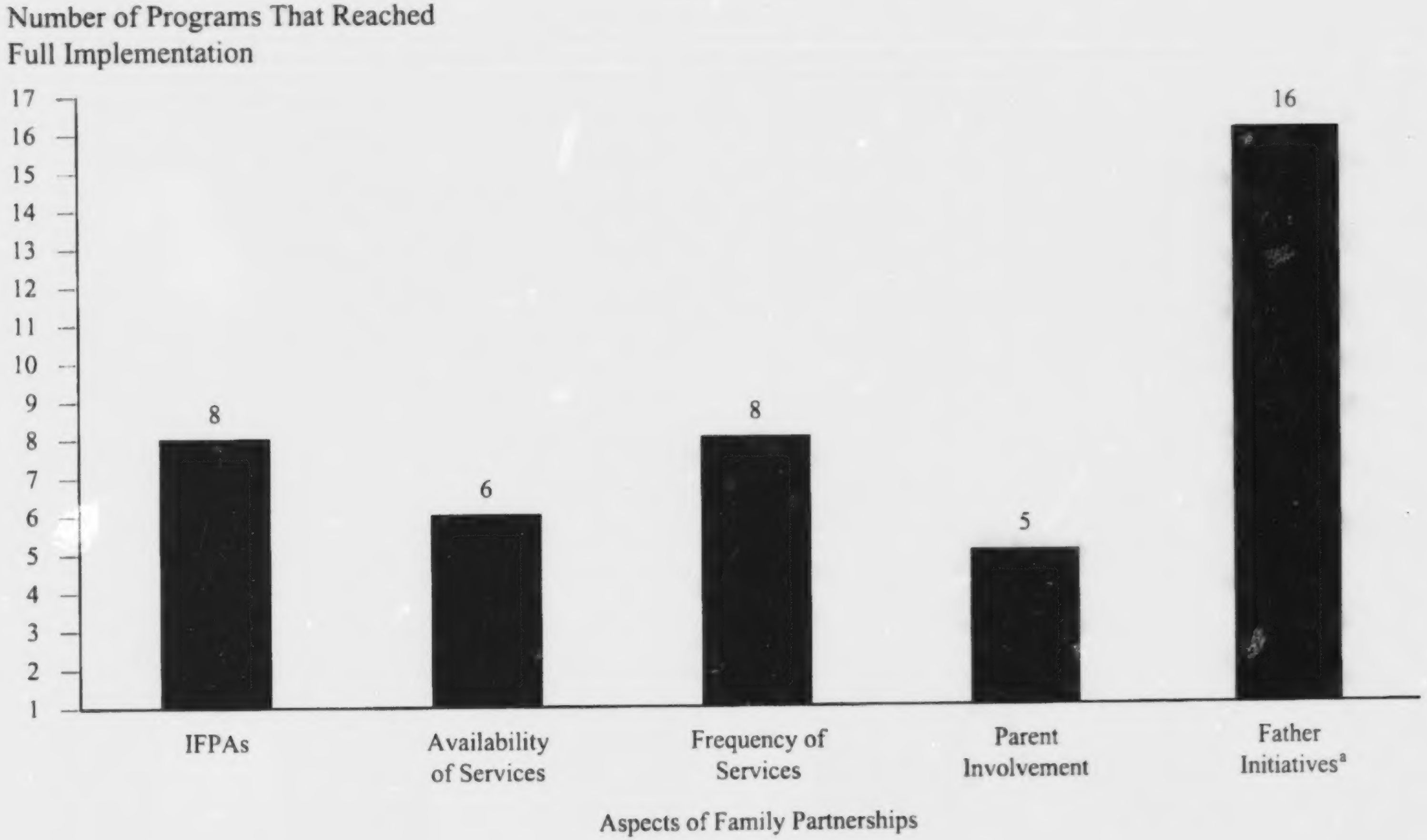
2. Availability of Services for Families

The extent to which programs make services available to families and the extent to which families receive these services regularly are also crucial measures of implementation of Early Head Start's family partnerships component. The revised Head Start Program Performance Standards require programs to make a wide range of services available to families, either by providing them directly or through referral. The standards also require programs to systematically follow up to ensure that families receive the services they need.

We rated programs as fully implemented in this area if they provided, either directly or through referral, the services families needed and systematically followed up with families and service

FIGURE IV.2

EARLY HEAD START FAMILY PARTNERSHIPS: ASPECTS THAT WERE FULLY IMPLEMENTED BY FALL 1997



Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

IFPA = Individual Family Partnership Agreement.

[a] We rated programs as fully implemented in this area if they had implemented specific strategies designed to increase father involvement, even if participation rates were low.

providers to ensure that families received needed services. In fall 1997, 6 of the 17 research programs had reached full implementation of these standards. Eleven programs had reached only moderate implementation in this area. Although these programs provided a variety of services either directly or through referral, they did not systematically follow up with families and service providers.

3. Frequency of Services for Families

We also rated programs on the frequency with which families received services. We rated programs as fully implemented if most families received services on a regular basis. In fall 1997, 8 of the 17 programs had fully implemented these standards. These programs held regular (at least monthly) case management meetings with families. They provided some health, employment, and other services to families directly and referred families to other community service providers for some services.

4. Parent Involvement

The revised Head Start Program Performance Standards require programs to involve parents in policymaking and program operations and to provide parents with opportunities to participate in the program as volunteers or employees. We rated programs as fully implemented if they strongly encouraged parent involvement in planning and carrying out program activities, provided multiple opportunities for participation in policy groups and volunteer activities, and involved at least half of the parents in some capacity.[3] Across all of the dimensions of the family partnership component that we assessed, research programs had the most difficulty reaching full implementation of the parent involvement requirements. Five programs had reached full implementation of parent involvement activities in fall 1997. Three of these were center-based programs and two were home-based programs.

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[3] We rated parent involvement in child development services as part of the Early Child Development and Health Services rating scale. For a discussion of parent involvement in child development services, see pages 27-28.

Center-based programs involved parents in several ways. They formed Parent Committees that met to discuss the operation of each center. All of the center-based programs and many of the mixed-approach programs also provided volunteer opportunities in center classrooms, playgrounds, kitchens, and offices. Even for parents who could not volunteer when centers were open, centers provided a focal point for volunteer activities. For example, parents made bibs and other items for the centers, cleaned and made repairs on weekends, and raised money for toys, playground equipment, and other materials. One center-based program did not reach full implementation of the parent involvement requirements in fall 1997. In this program, fewer than half of the parents were involved in planning program activities, the Policy Council did not meet regularly, and volunteer opportunities for parents were limited.

In contrast, home-based and some mixed-approach programs had more difficulty involving parents in policymaking and volunteer activities. When families received services primarily in their homes, home-based and mixed-approach programs sometimes found it difficult to achieve good levels of attendance at Policy Council and Parent Committee meetings. In addition, some home-based programs found it difficult to develop volunteer opportunities for parents, since most program activities occur in individual homes.

5. Father Initiatives

While the revised Head Start Program Performance Standards contain specific requirements for parent involvement in Early Head Start, they do not specifically require developing special initiatives designed to promote father involvement. Nevertheless, we included special initiatives for fathers in our implementation rating scale for family partnerships because of the Head Start Bureau's emphasis on promoting father involvement in the lives of their children and in the program, and the impetus created by the federal Fatherhood Initiative.[4] Moreover, increased emphasis on father involvement was recommended by the Advisory Committee on Services for Families with Infants and Toddlers, which created the initial blueprint for the Early Head Start program (U. S. Department of Health and Human Services 1994). In contrast to parent involvement, in which we rated programs in part based on parent participation rates, we rated programs as fully implemented in this area if they implemented specific strategies designed to increase father involvement, even if father participation rates were low.

In fall 1997, 16 of the 17 research programs had implemented at least one special initiative to promote father involvement. Many of these programs hired male staff members to conduct outreach and provide services to male family members and father figures of Early Head Start children. In addition, these research programs worked to involve fathers in the program by encouraging their participation in home visits and parent meetings, holding special events and activities for men, and facilitating men's support groups. Several research programs also undertook special efforts to make the program environment welcoming for fathers. For example, programs displayed posters of fathers and children, tried to make office decor more inviting to men, and held special events to greet fathers and other male family members.

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[4] The federal Fatherhood Initiative was galvanized by President Clinton's request for federal agencies to assume greater leadership in promoting the involvement of fathers and focusing on their contributions to their children's well-being. The activities of this initiative have involved the White House, several key federal statistical agencies, the Family and Child Well-Being Research Network (a consortium of seven scholars funded by the National Institute of Child Health and Human Development--NICHD), the National Center on Fathers and Families, and others. Together, these activities have created a national momentum for reconceptualizing the way fathers are incorporated into policies. They also have set forward a research agenda that will improve federal data on fathers and will support the development of policies and programs that recognize the emotional, psychological, and economic contributions that fathers can make to the development of their children.

B. COMMUNITY PARTNERSHIPS

Just as children develop within families, families develop within communities. As described in the Early Head Start grant announcement, one goal of the program is to create within communities an environment of shared responsibility for the development of children and families. Thus, the revised Head Start Program Performance Standards emphasize the importance of building community partnerships and improving the availability of community services for children and families. To assess the extent of implementation of Early Head Start's community partnerships component, we examined the extent to which research programs (1) developed collaborative relationships with other service providers, (2) established program advisory committees made up of community members, and (3) developed transition plans for children leaving the program.[5] We then assigned an overall implementation rating to each research program's community partnerships component.

Based on an assessment of these three aspects of community partnerships, eight research programs reached full implementation of Early Head Start community partnership activities in fall 1997 (Figure IV.3). Another eight research programs reached moderate levels of implementation in this area, because some aspects of these programs' community partnerships component were not

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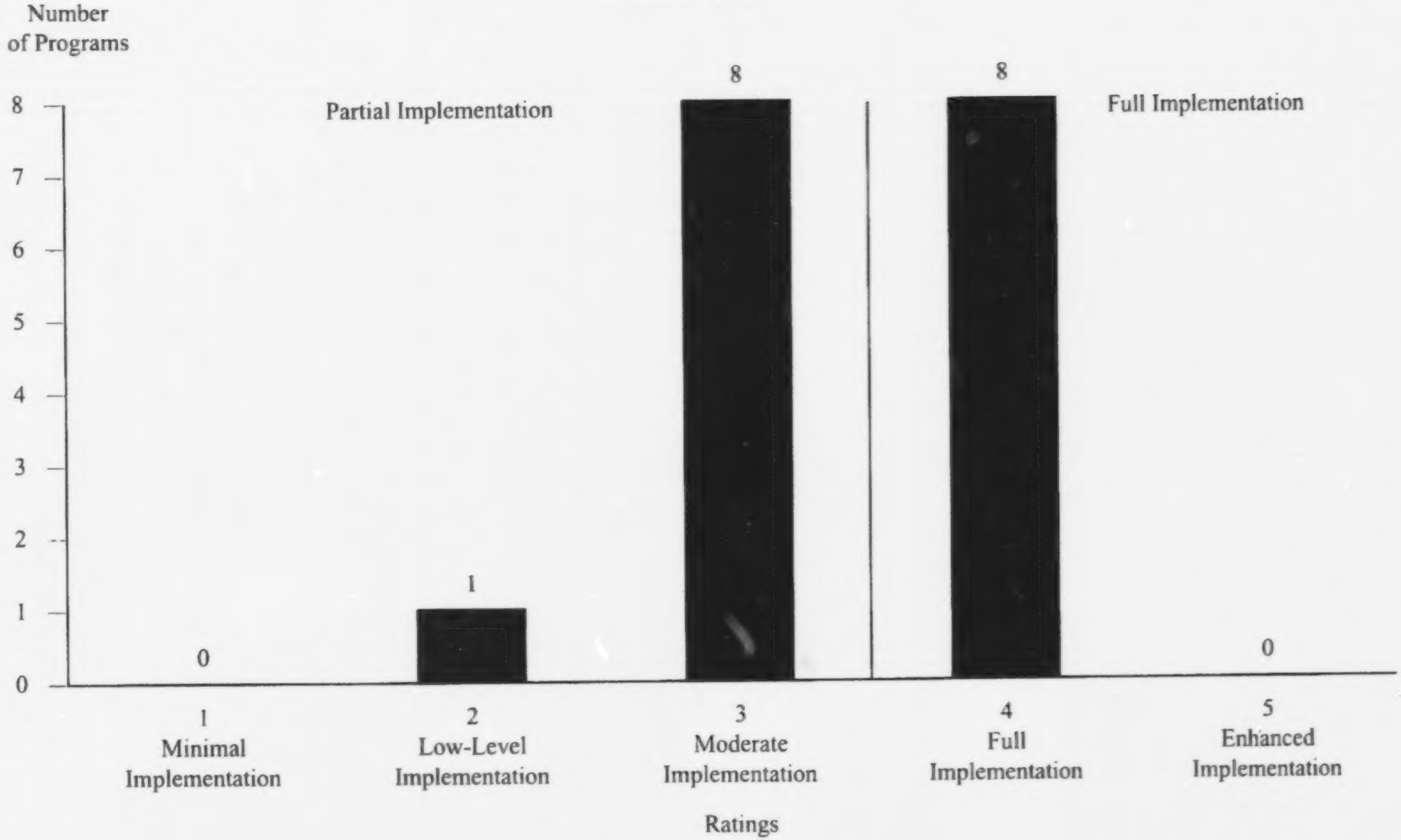
[5] Appendix B contains a detailed description of the rating criteria we developed for each of these dimensions of community partnership activities.

FIGURE IV.3

EARLY HEAD START COMMUNITY PARTNERSHIPS
IMPLEMENTATION RATINGS
FALL 1997



Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

Note: Implementation ratings for community partnerships represent the average rating across all the dimensions we examined. Programs rated as fully implemented achieved full implementation in most of the dimensions we examined, but did not necessarily achieve full implementation in every dimension (see Figure IV.4 for a list of dimensions).

yet fully implemented. Across the three program types, center-based programs were most likely to have fully implemented the community partnerships component. Among center-based programs, 75 percent achieved full implementation, compared with about 40 percent of home-based and mixed-approach programs.

1. Collaborative Relationships

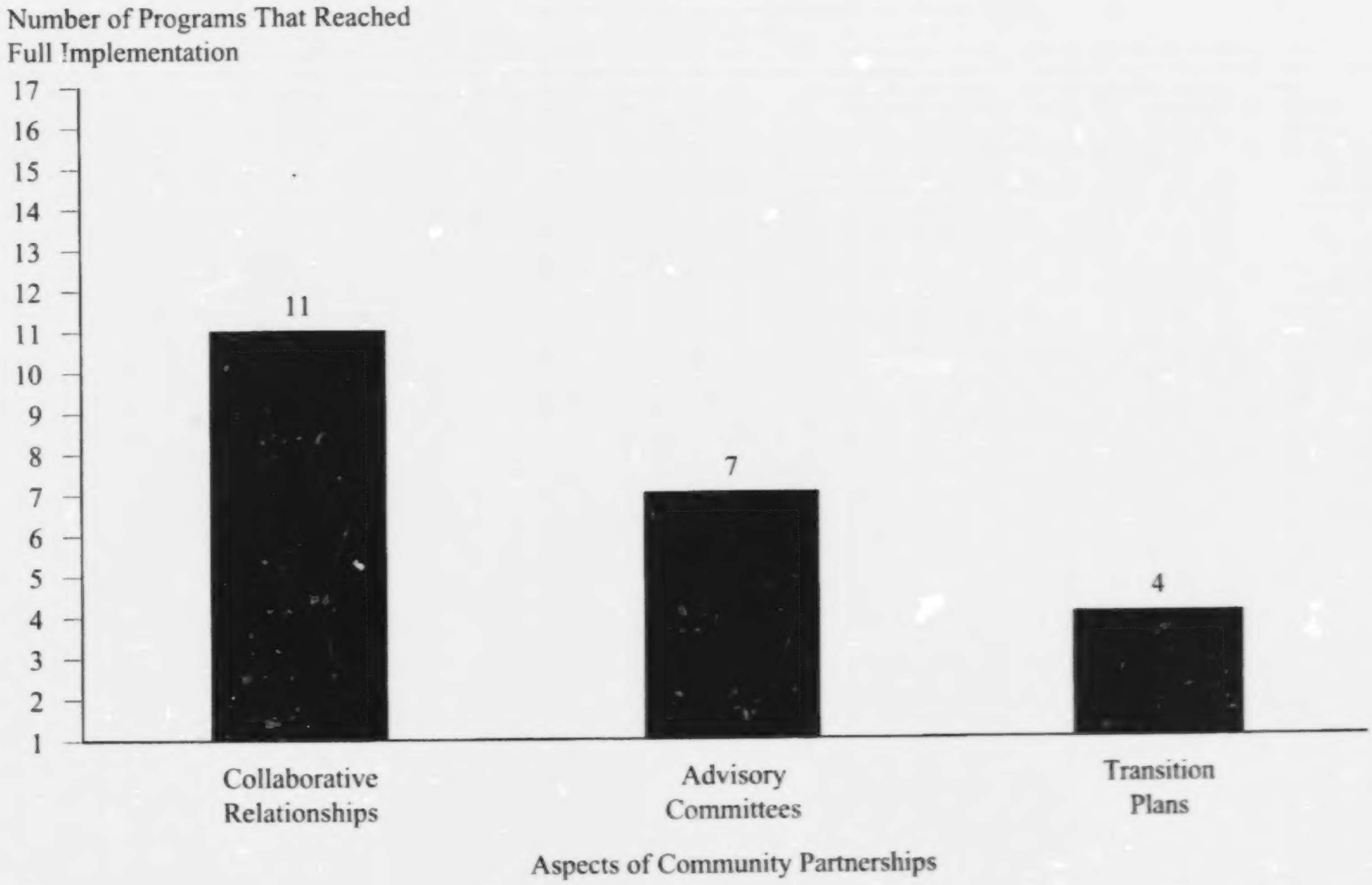
The revised Head Start Program Performance Standards require programs to develop collaborative relationships with community service providers, with the goal of increasing access to services that are responsive to the needs of children and families. Developing collaborative relationships with other service providers was the most fully implemented aspect of community partnership activities; 11 research programs had achieved full implementation in this area in fall 1997 (Figure IV.4). These research programs had established both formal and informal collaborative agreements with a broad range of community service providers. Moreover, program staff maintained frequent communication with these service providers to coordinate services for families, and staff from some programs actively participated in local coordinating groups of community service providers. Some Early Head Start program staff members held leadership roles within these groups.

2. Advisory Committees

The revised Head Start Program Performance Standards also require programs to establish health advisory committees made up of community professionals and volunteers and to establish other community advisory committees as appropriate to guide the program on service delivery issues. We rated programs as fully implemented if they had established a health advisory committee that met regularly, involved other community health services providers, and discussed infant and toddler health issues.

FIGURE IV.4

EARLY HEAD START COMMUNITY PARTNERSHIPS: ASPECTS THAT WERE FULLY IMPLEMENTED BY FALL 1997



Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

Seven research programs reached full implementation of this aspect of community partnership activities in fall 1997. Although all but one of the research programs had established a health advisory committee, some did not meet regularly, and others, because they were established initially to provide guidance to large Head Start programs, did not yet focus on infant and toddler health issues. A few research programs had established additional advisory committees to provide program staff members with guidance on other issues such as employment services, social services for adults, parent involvement, and disabilities. Advisory committees were typically made up of representatives from other social service agencies and programs, professionals from the community, local officials, community representatives, and parents.

3. Transition Planning

To ensure a smooth transition from Early Head Start to Head Start or another preschool program, the revised Head Start Program Performance Standards require programs to work in collaboration with parents to develop individualized transition plans for all children at least six months before their third birthday. We rated programs as fully implemented in this area if they had established transition planning procedures and if all children within six months of their third birthday had transition plans in place.

In fall 1997, only four of the research programs had fully implemented these transition planning requirements. Because most families enrolled in the research programs when their children were 12 months of age or younger, several programs did not yet have children who needed transition plans, and thus had not yet focused on this aspect of the program. Other research programs had developed procedures for planning transitions, but they had not yet implemented them for all children who were within six months of their third birthday. Finally, several research programs, most frequently those run by agencies that also operated Head Start programs, planned to transition all children into their

Head Start programs and had not yet explored alternative programs for children and families who were no longer eligible for Head Start or wanted to explore other options.

V. PROGRAM DESIGN AND MANAGEMENT

To facilitate program implementation, promote high-quality services, and ensure coordination across all components, Early Head Start programs need a competent, well-trained staff and strong management systems. In the revised Head Start Program Performance Standards and the Early Head Start grant announcement, the Head Start Bureau provides guidelines to promote hiring, training, and retaining program staff members who are skilled and knowledgeable about services for families with infants and toddlers. The Head Start Bureau also requires programs to implement specific management systems and procedures to ensure program oversight and planning to promote continuous improvement. This chapter describes the extent to which the research programs implemented central elements of these standards for developing staff and management systems.

A. STAFF DEVELOPMENT

To operate high-quality Early Head Start programs, grantees must hire and retain competent staff members who are well trained, supervised, and compensated. The revised Head Start Program Performance Standards and the Early Head Start grant announcement emphasize the importance of hiring competent staff; providing supervision and training activities that focus on relationship building and provide opportunities for practice, feedback, and reflection; and rewarding high-quality performance through compensation and opportunities for career advancement. Thus, to measure the extent of implementation in the area of staff development, we examined five aspects of each research program's staff development activities: (1) supervision, (2) training, (3) staff retention, (4) compensation, and (5) staff morale.[1]

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[1] Appendix B contains a detailed description of the rating criteria we developed for each of these dimensions of staff development activities.

At the time of our site visits in fall 1997, the research programs had made significant progress in implementing the key elements of staff development that we examined. Across all research programs, staff development was the most fully implemented of the five major program components we assessed; 11 programs had reached full implementation of this component by fall 1997 (Figure V.1). About 75 percent of center-based programs, 63 percent of home-based programs, and 60 percent of mixed-approach programs had fully implemented the staff development component.[2]

1. Supervision

Supervision and training were the strongest elements of the research programs' staff development efforts. Twelve research programs had fully implemented these aspects of staff development in fall 1997 (Figure V.2). The revised Head Start Program Performance Standards and the Early Head Start grant announcement mandate that programs implement a system of supervision, training, and mentoring that emphasizes relationship building, employs experiential learning techniques, and provides regular opportunities for feedback on performance. All staff members in fully implemented research programs received regular supervision that included support from other staff members and constructive feedback on their performance. In five research programs, supervision included both individual and group supervision sessions, such as discussion and support groups for home visitors and for teachers in centers. In addition, the feedback provided in these five research programs was based in part on supervisors' observations of service delivery, either by accompanying staff members on home visits or observing them working directly with children and parents in centers.

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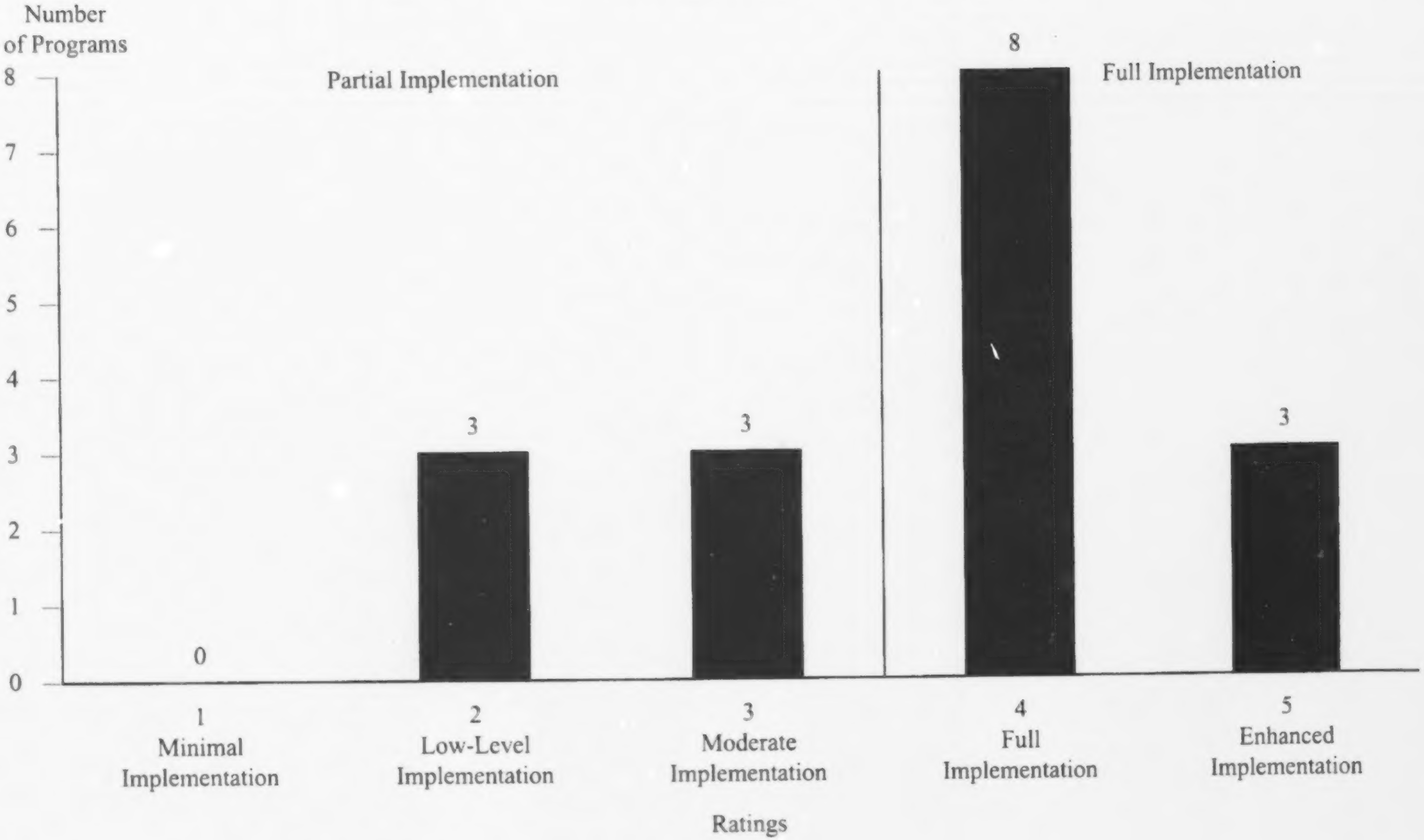
[2] See Volume I for greater details on programs' staff development activities.

FIGURE V.1

EARLY HEAD START STAFF DEVELOPMENT ACTIVITIES IMPLEMENTATION RATINGS FALL 1997

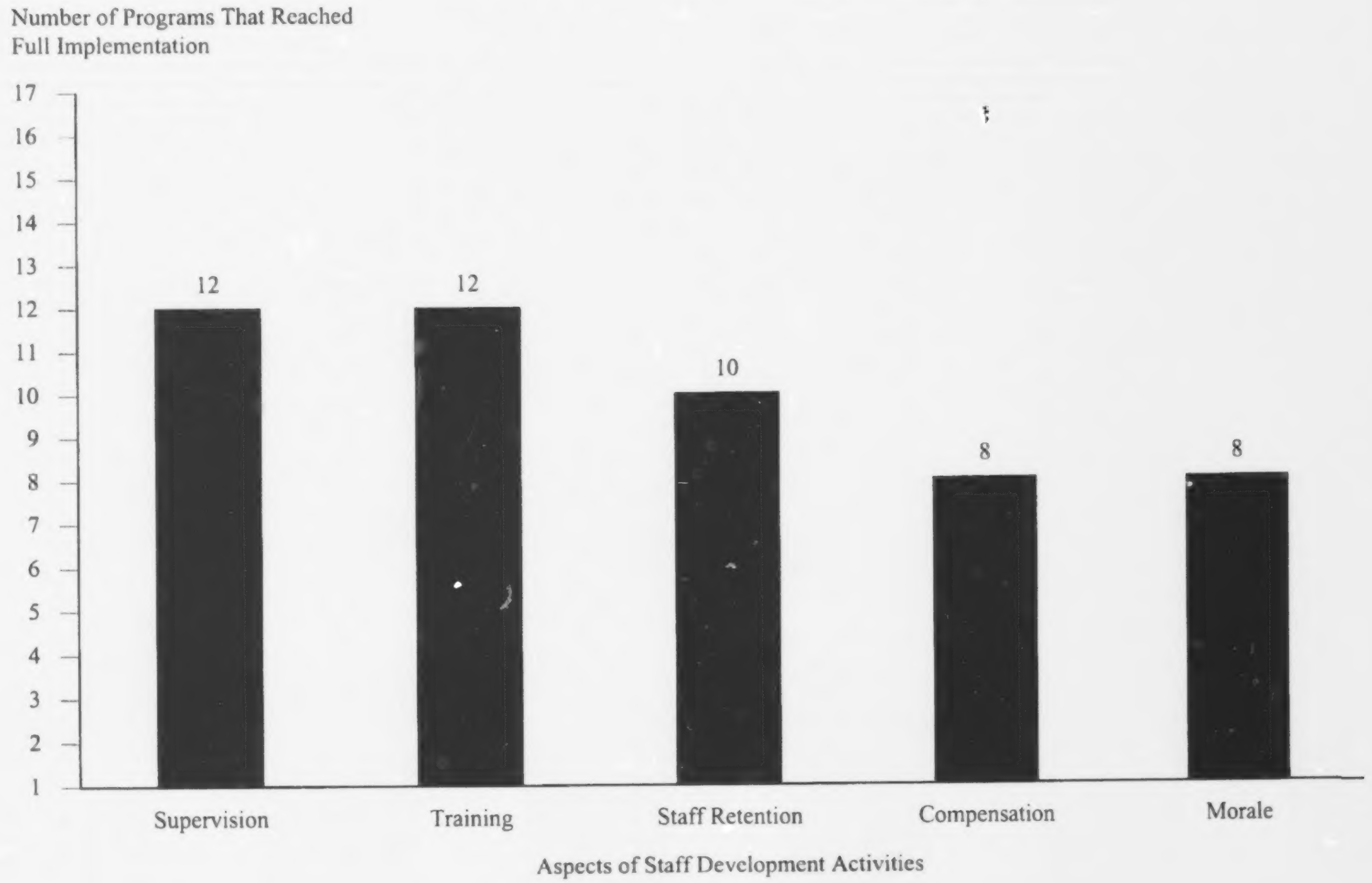


Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

Note: Implementation ratings for staff development represent the average rating across all the dimensions we examined. Programs rated as fully implemented achieved full implementation in most of the dimensions we examined, but did not necessarily achieve full implementation in every dimension (see Figure V.2 for a list of dimensions).

FIGURE V.2

EARLY HEAD START STAFF DEVELOPMENT ACTIVITIES: ASPECTS THAT WERE FULLY IMPLEMENTED BY FALL 1997



Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

Most of the programs that had not yet fully implemented the staff development component in fall 1997 had undergone significant staff transitions during the previous year. Because these transitions typically involved supervisory staff, new supervision practices and procedures were still in the process of being developed at the time we visited these programs.

2. Training

In addition to strong supervision, staff in most research programs received many opportunities to participate in training on child development and a wide variety of other topics. Twelve research programs had fully implemented staff training requirements in fall 1997. These programs determined their training needs through staff surveys and input from supervisors, technical assistance providers, and program officers, and they planned training based on this needs assessment. They provided intensive preservice training, regular opportunities to participate in in-house training, and opportunities to attend outside training sessions and conferences organized by the Head Start Bureau, technical assistance providers, and other community organizations. Almost all research programs provided opportunities for staff members to obtain a Child Development Associate (CDA) credential, and a few provided opportunities for them to obtain other certifications as well. Six research programs provided training that emphasized relationship building and employed experiential learning techniques. Five programs had reached only partial implementation by fall 1997 because they had not provided training to all staff in multiple areas or had not developed a training plan.

3. Staff Retention

The revised Head Start Program Performance Standards and the Early Head Start grant announcement stress the need to develop and maintain secure, continuous relationships between staff, children, and parents and to avoid frequent turnover of key people in children's lives. Therefore, retaining personnel is an important staff development goal for Early Head Start programs.

Ten research programs reached full implementation in this area (according to the rating scales we developed) by maintaining low staff turnover rates (less than 20 percent) in the year prior to the fall 1997 site visits. Three additional research programs experienced moderate turnover (20 to 29 percent of staff) in the year prior to the site visits. Four research programs experienced high (30 to 39 percent of staff) or very high (more than 39 percent of staff) turnover. Most programs with high turnover had also experienced changes in program leadership during the previous year.

4. Compensation

In addition to retaining staff, the Early Head Start grant announcement emphasizes the importance of adequate staff compensation to promote and reward high-quality performance and professional development. Eight research programs had reached full implementation of this staff compensation mandate in fall 1997 by providing salaries and benefits that program staff considered to be above the average of similar positions in other community agencies. At eight additional research programs, staff considered the salaries and benefits offered to be at the same level, on average, as those of similar community agencies. Salaries and benefits were considered to be low, in comparison to similar community agencies, at only one research program.

5. Staff Morale

The final aspect of staff development that we examined was staff morale. Although staff morale is not specifically addressed in the revised Head Start Program Performance Standards or the Early Head Start grant announcement, we included it in the rating scale because it is an important measure of the extent to which the programs were able to create a supportive environment that enables staff to perform and develop. We rated programs as fully implemented in this area if staff morale was high or very high in fall 1997.

In fall 1997, no research programs reported low morale among Early Head Start staff. Based on staff reports during site visits and in the staff surveys, staff morale appeared to be high in eight research programs and average in nine research programs. Personnel at a few research programs described periods of low staff morale during the year prior to our site visits. However, in each of these situations, changes in leadership or other aspects of the research program had occurred, which had improved staff morale prior to our visits.

B. MANAGEMENT SYSTEMS

Early Head Start programs need strong management systems to ensure smooth coordination among all program components and high-quality service delivery. The revised Head Start Program Performance Standards require a system of shared program governance in which parents participate in decision making, as well as management systems that ensure careful program planning and community involvement. To assess the extent of implementation of each research program's management component, we examined four key aspects of the programs' management systems: (1) establishment of an active Policy Council; (2) development of goals, objectives, and plans; (3) program self-assessment; and (4) community needs assessment.[3] Seven research programs reached full implementation of these program management requirements in fall 1997 (Figure V.3). Six additional research programs achieved a moderate level of implementation in this area, because some aspects of their management systems that we assessed were not yet fully implemented.

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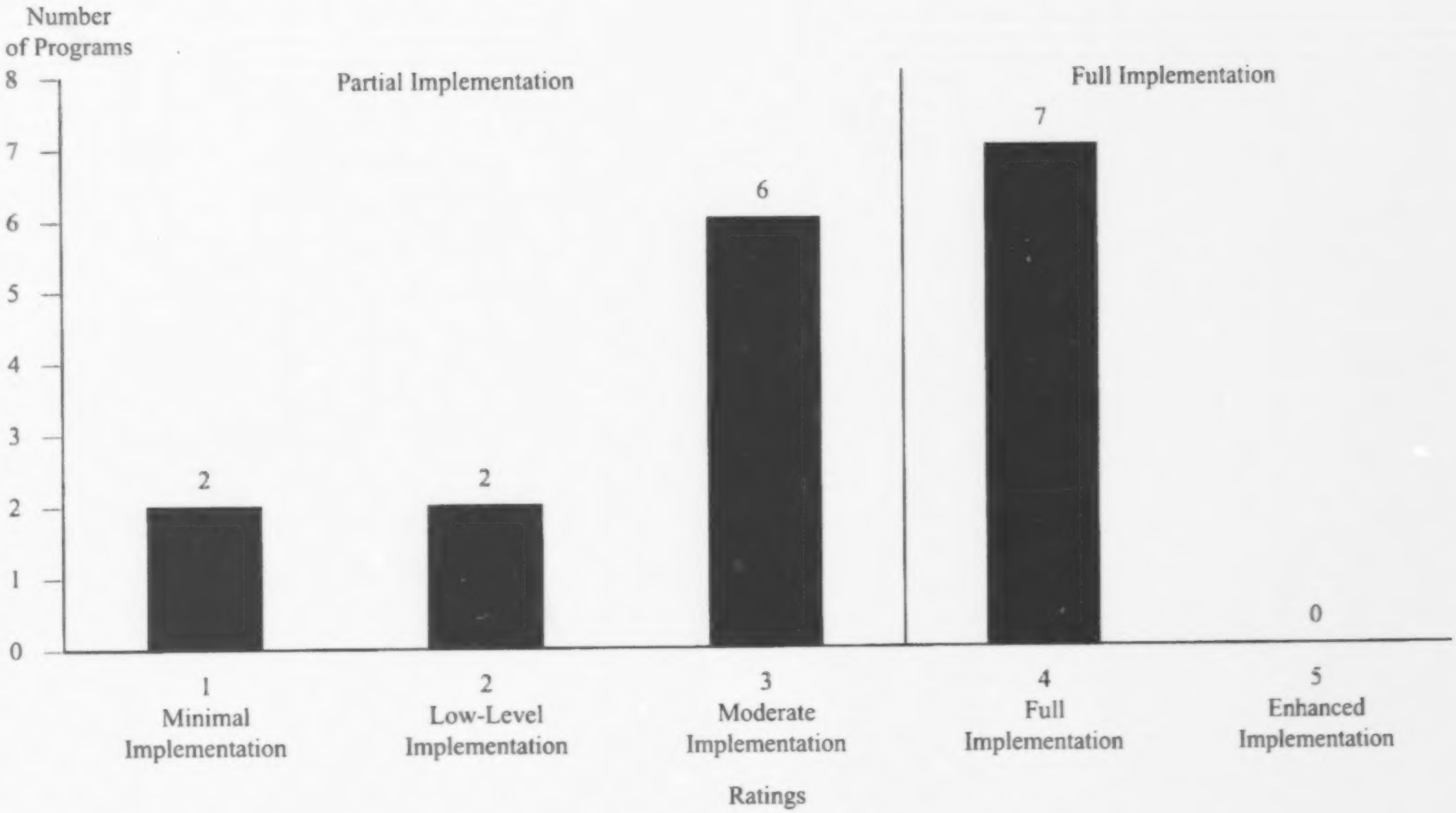
[3] Appendix B contains a detailed description of the rating criteria we developed for each of these dimensions of program management activities. We recognize other aspects of management systems exist that we were not able to evaluate.

FIGURE V.3

EARLY HEAD START MANAGEMENT SYSTEMS IMPLEMENTATION RATINGS FALL 1997



Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

Note: Implementation ratings for management systems represent the average rating across all the dimensions we examined. Programs rated as fully implemented achieved full implementation in most of the dimensions we examined, but did not necessarily achieve full implementation in every dimension (see Figure V.4 for a list of dimensions).

1. Policy Council

The revised Head Start Program Performance Standards require programs to establish Policy Councils charged with developing and approving key program policies and procedures. The standards further mandate that Policy Councils include both parents and community members, with at least 51 percent of the membership made up of parents of currently enrolled children. We rated programs as fully implemented in this area if they had established a Policy Council that met regularly and was involved in program decision making.

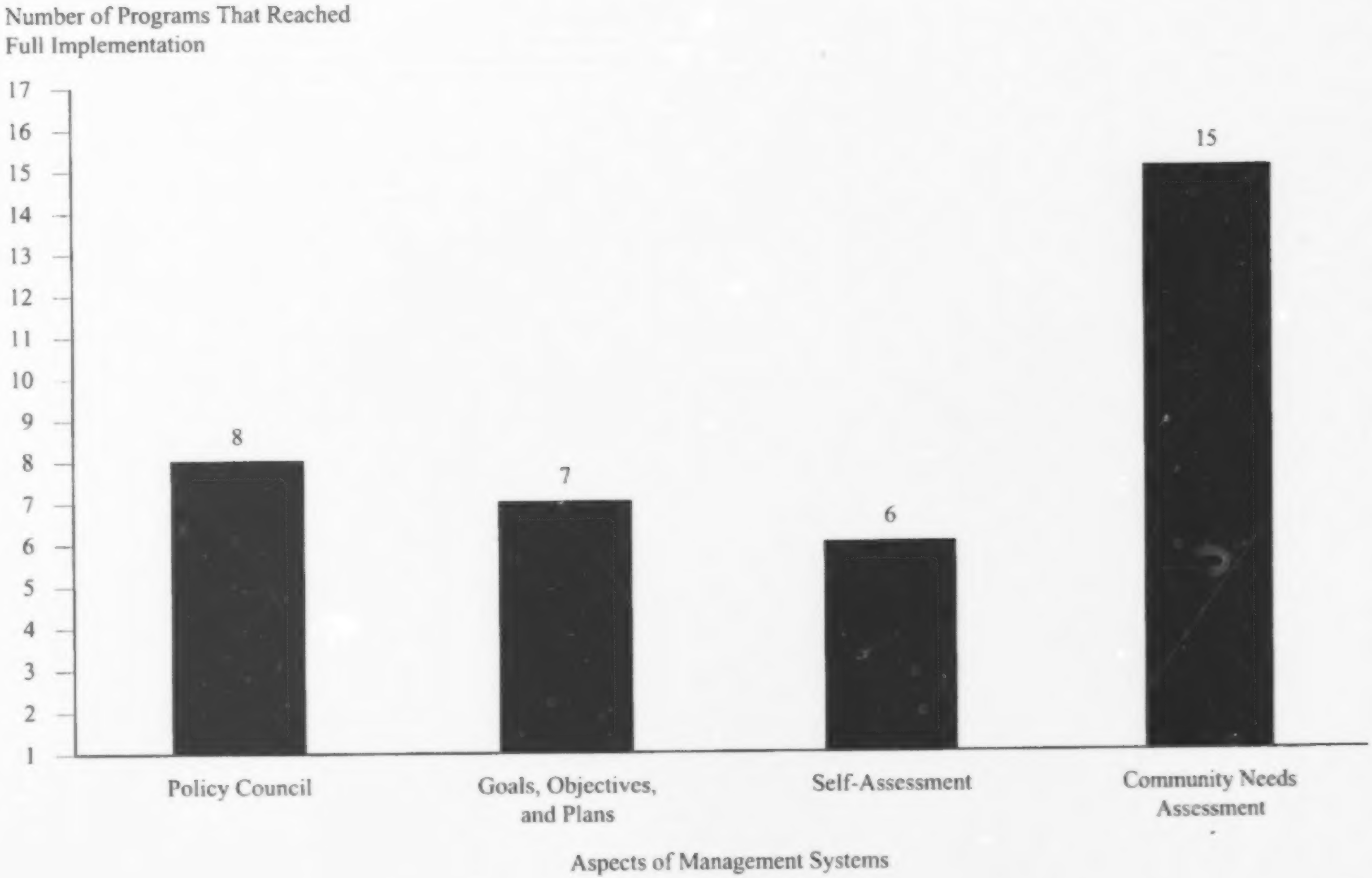
In fall 1997, eight research programs had reached full implementation of these Policy Council requirements (Figure V.4). Three additional programs had achieved moderate levels of implementation in this area. These three research programs had established Policy Councils that met regularly, but the councils were not significantly involved in program decision making. Five research programs had achieved only low levels of implementation in the area because, while Policy Councils had been established, they did not meet regularly. One research program was still in the process of forming its Policy Council in fall 1997.

2. Goals, Objectives, and Plans

To ensure careful and inclusive planning, the revised Head Start Program Performance Standards require programs to develop multiyear goals, short-term objectives, and written plans for implementing services in each program area. Furthermore, these goals, objectives, and plans must be developed in consultation with programs' Policy Councils, advisory groups, staff, parents, and other community members.

FIGURE V.4

EARLY HEAD START MANAGEMENT SYSTEMS: ASPECTS THAT WERE FULLY IMPLEMENTED BY FALL 1997



Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

Seven research programs had fully implemented these requirements in fall 1997. Four additional research programs had achieved moderate implementation in this area. These programs had developed goals, objectives, and plans but needed to update them. Four research programs had developed goals, objectives, and plans but had only partially implemented them, and two research programs had not yet developed written goals and plans.

3. Program Self-Assessment

To promote continuous improvement, the revised Head Start Program Performance Standards also require programs to conduct an annual self-assessment of their progress toward meeting program goals and objectives and their compliance with the performance standards. In addition to staff members, this self-assessment must involve Policy Council members, parents, and other community members.

In fall 1997, six research programs had fully implemented these requirements by conducting a self-assessment in the previous year. A seventh research program had conducted an informal self-assessment, but the results had not been documented in program records. Four research programs planned to conduct self-assessments but had not yet done so at the time of our visits. Six research programs had not conducted self-assessments and had not yet planned to do so.

4. Community Needs Assessment

To promote program planning that takes into account community needs and resources, the revised Head Start Program Performance Standards require programs to conduct an assessment of community strengths, needs, and resources at least once every three years. Almost all research programs reached full implementation in this area in fall 1997. Fifteen research programs had completed a community needs assessment within the previous three years. The Early Head Start grant announcement required that initial grant proposals include a community needs assessment, so almost all research programs had completed this task in 1995 when they developed their initial grant proposals.

VI. SUMMING UP AND LOOKING AHEAD

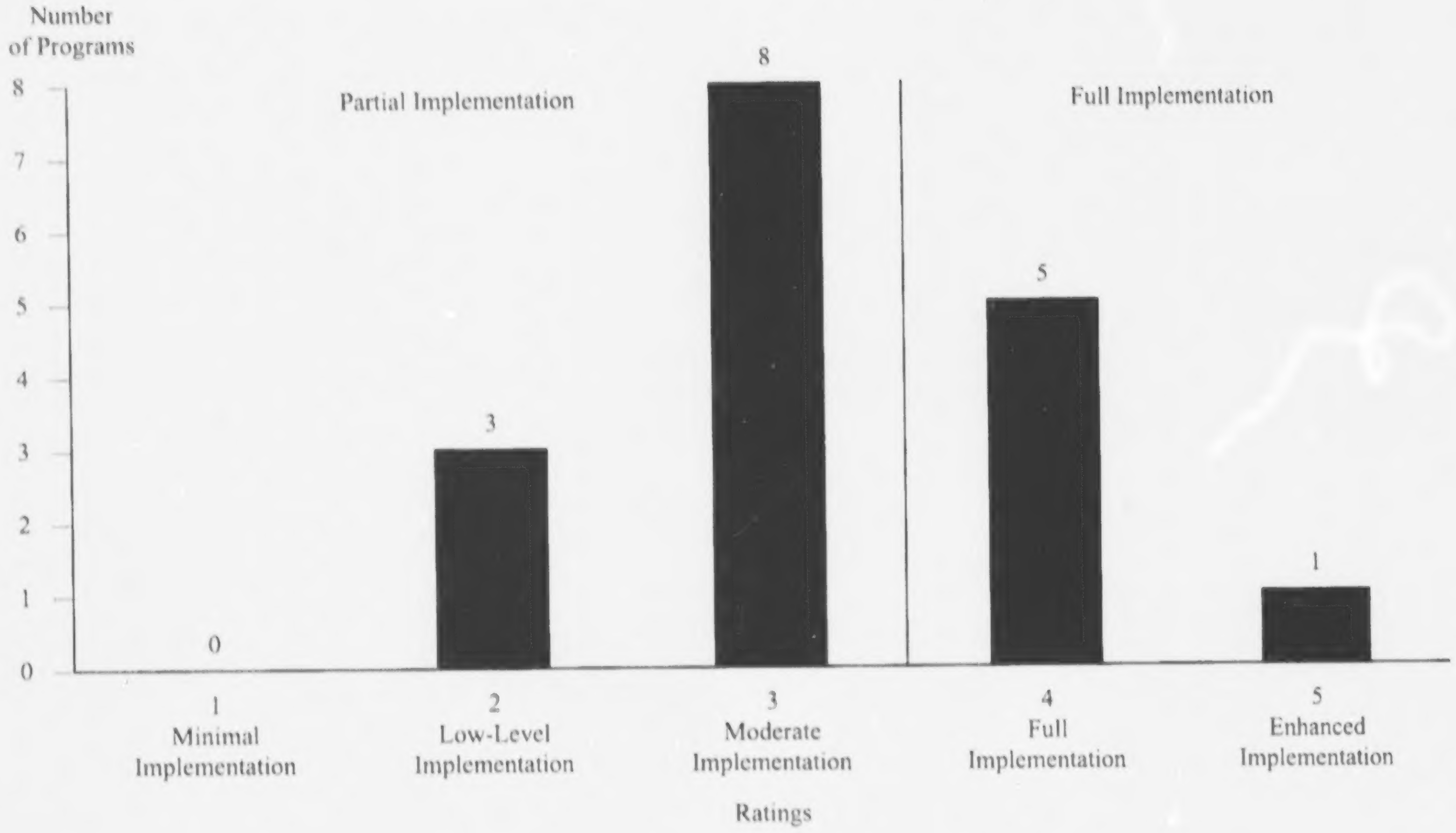
At the time of our site visits in fall 1997, the Early Head Start research programs were at a very early stage of implementation. Most of the research programs had been serving families for about one year; some had been serving families for even less time. Many were still putting some service and management systems in place and seeking guidance from the Head Start Bureau and the technical assistance network on the revised Head Start Program Performance Standards. All programs were grappling with how to respond to families' changing service needs in the wake of welfare reform.

Even at this early stage, six programs had fully implemented Early Head Start according to our ratings in fall 1997 (Figure VI.1). These programs had fully implemented all or nearly all of the five program components, and all of them had fully implemented the early childhood development and health services and staff development requirements that we examined. All of these programs were building on previous experience serving families with young children. Two of the six programs had experience as Head Start grantees, three were former Comprehensive Child Development Program (CCDP) programs, and one had experience operating another early childhood development program. The six fully implemented programs were evenly divided across program approaches. Two were center-based, two were home-based, and two employed a mixed approach to serving families.

Eight research programs had reached moderate levels of implementation in fall 1997 according to our ratings. Most of these programs had fully implemented some, but not all, of the five program components we assessed. Two had fully implemented early childhood development and health services and four had fully implemented family partnerships. Four of these programs were home-based, two were center-based, and two were mixed-approach programs.

FIGURE VI.1

OVERALL IMPLEMENTATION OF EARLY HEAD START IMPLEMENTATION RATINGS FALL 1997



Source: Site visits conducted in fall 1997 to 17 Early Head Start research programs.

Note: Implementation ratings represent the average rating across all program components. Programs rated as fully implemented achieved full implementation in most of the components we examined, but did not necessarily achieve full implementation in every dimension.

Three research programs had reached only low levels of implementation according to our ratings. One of these programs was a mixed-approach program, and two were home-based. These programs had not yet reached full implementation of any of the program components we examined, but they had achieved a moderate level of implementation in at least one area. Two of these programs had only minimally implemented the management systems we looked for.

The research programs faced important challenges and experienced successes during their first two years of program funding and their first year of serving families. Assigning implementation ratings to programs enabled us to identify patterns of challenges and strengths that were common across the research programs in fall 1997. The remainder of this chapter summarizes the main challenges and successes that emerged from the our first round of implementation ratings and looks ahead to the next round of implementation ratings based on information collected during site visits in fall 1999.

A. EARLY IMPLEMENTATION CHALLENGES REFLECTED IN THE IMPLEMENTATION RATINGS

The implementation ratings discussed in previous chapters point to several themes related to the difficulties some programs had in becoming fully implemented by fall 1997. Several of these themes reflect the policy and community context in which the research programs were implemented. Others reflect the programs' early stage of implementation. Identifying challenges may help explain why some programs were able to become implemented early while others were not.

1. Research programs that provided home-based services experienced challenges in completing the required number of home visits with most families.

In fall 1997, only 6 of the 13 research programs providing home-based services were able to complete at least two child development home visits per month with almost all families. During the site visits, program staff told us that they were still adjusting to the new demands imposed on families by welfare reform. Because more parents were working or attending school or training activities, their availability to participate in home visits had become more limited. Some programs responded by trying to conduct more home visits during evenings and on weekends. Home visitors reported, however, that families were often too tired and busy to focus on child development activities during evening visits and were too busy with other activities to meet with them on weekends.

2. **Many research programs had difficulty engaging parents in parent education and other group activities, although programs were successful in engaging parents in planning services for their children.**

Welfare reform also affected programs' ability to engage parents in parent education and program involvement activities away from home. Parents' work and school schedules made scheduling meetings and group socializations when most parents could attend very challenging. Programs found it difficult to achieve high participation rates, in part because of the competing demands on parents' time. For example, although 11 of 13 research programs providing home-based services offered regular group socialization activities, only two programs achieved regular participation by half or more of families in the home-based option. Many programs were seeking clarification about the nature of appropriate socialization activities for infants. Likewise, while almost all programs had implemented a special initiative to involve fathers, participation rates were low in most programs. Many programs, especially those implementing the home-based option, also found it difficult to achieve good levels of attendance at Parent Committee and Policy Council meetings and to develop volunteer opportunities for parents.

3. Most programs did not have systems in place to ensure that all child care arrangements used by Early Head Start families met the revised Head Start Program Performance Standards.

Early Head Start programs are responsible for ensuring that child care arrangements used by Early Head Start families comply with the revised Head Start Program Performance Standards, whether care is provided in Early Head Start centers or in the community. At the time of our fall 1997 site visits, however, this requirement was not clear to all of the research programs. The revised Performance Standards had not yet taken effect and programs were still seeking guidance from the Head Start Bureau on some program requirements. The Head Start Bureau's expectations regarding child care were clarified during monitoring visits conducted in early 1998.

A few programs were taking steps to ensure that community child care arrangements used by program families met the standards in fall 1997, and they encountered several challenges. First, some programs found that the supply of good-quality child care in their communities was limited. For these programs, helping families arrange good-quality child care became a more complex task that involved increasing the supply of good-quality care in the community and helping providers work towards meeting the performance standards. Several programs developed partnerships with community providers to work toward meeting the performance standards. Second, building partnerships with child care providers and making the changes in community child care settings necessary to meet the performance standards takes time. Some providers were not set up to meet the standards quickly, even if they were eager to do so. In some cases, resources were needed for staff training and for reducing ratios and group sizes to levels required by the performance standards. Understandably, some parents preferred to make arrangements for child care on their own. Parents often chose relatives and other informal providers whom they knew and trusted, and these providers did not always meet the performance standards. A few programs tried to develop relationships with these providers but found it challenging to gain the trust of informal providers and work with them on quality improvements.

4. Many programs had not yet implemented transition-planning requirements.

In fall 1997, some research programs had developed procedures for planning transitions but had not yet implemented them for all children within six months of their third birthday. Some of these communities had few good-quality preschool programs that the staff believed could meet the needs of families with children transitioning out of Early Head Start. For example, some programs reported that the local Head Start program did not serve 3-year-olds. Other programs did not have arrangements with area Head Start programs to give priority to Early Head Start children and were not able to arrange enrollment for all eligible transitioning children.

Several research program grantees also operated Head Start programs. These programs usually planned to transition all Early Head Start children into their Head Start programs, and some had not identified alternatives for families who were no longer eligible for Head Start. In some communities, staff reported that no other good-quality, affordable preschool programs were available.

Finally, a few programs had not yet developed transition-planning procedures because in fall 1997 they did not yet have children who needed transition plans (all children were younger than age 2 and a half). Because of the programs' early stage of development, staff members at some research sites reported that transition-planning procedures were not the program's highest priority, although they would become more important as children got older and families needed to begin planning for transitions.

5. Many programs were still putting management systems in place.

In part due to the programs' early stage of implementation, many had not yet developed systems for tracking and managing services. For example, while many programs followed up on child health needs, about one-third had procedures in place to systematically track receipt of required health services. In addition, about half of the research programs had not yet put systems in place for updating individual family partnership agreements. Similarly, Policy Councils, advisory committees, and self-assessment procedures were not yet fully operational or were still in the planning stages in some programs.

Several factors accounted for delays in establishing management systems. First, several programs experienced turnover of staff in key positions, which delayed the development of management systems and procedures or resulted in changes to systems that had been in place. Some programs had planned to use the Head Start Family Information System for tracking service receipt, and delays in its development and implementation affected programs' capacity to systematically track services. Some programs, especially those that did not have previous experience providing Head Start services, did not clearly understand the Head Start management requirements and were still seeking clarification from the Head Start Bureau. Finally, perhaps due to the programs' early stage of development, in fall 1997 some programs were immersed in staff training and implementing program services. In these programs, establishing management systems had not yet become a high priority.

6. A number of programs were reconfiguring previous program models.

Several programs were reconfiguring services following different approaches they had been using under previous program models. No particular experience in delivering services in the past seemed to offer programs an easy start in the early period of implementation; rather, each configuration of background experiences had its own challenges. For example, former CCDP programs had to adjust to the enhanced child development focus of Early Head Start. Three of the former CCDPs did this readily, two were somewhat successful, but the other two struggled to make the transition and were among the least implemented of the programs. Grantees with former preschool-age Head Start program experience had to resolve issues related to global program resources and make appropriate changes in order to serve infants and toddlers. Some did that smoothly; some did not. Programs that had not been Head Start or CCDP grantees had different challenges in learning about the Head Start requirements. Of these programs in 1997, one was fully implemented and the others were moderately implemented.

B. EARLY IMPLEMENTATION SUCCESSES REFLECTED IN THE IMPLEMENTATION RATINGS

Despite these challenges and the programs' early stage of implementation, the implementation ratings point to several areas in which most programs had notable successes in implementing program requirements in fall 1997.

1. Most programs provided highly individualized services.

Most of the research programs provided services that were tailored to the individual needs and circumstances of families and children. For example, 14 of the 17 research programs provided individualized child development services that were responsive to needs expressed by parents and almost always provided services in the language families spoke at home (usually English or Spanish). Most programs conducted regular developmental assessments, used the results to plan services, and involved parents in the service-planning process. Finally, many programs had completed family partnership agreements with most families and, in the process, worked with families to set and prioritize their own goals.

2. **Almost two-thirds of the research programs had fully implemented the staff development component.**

By fall 1997, most of the research programs had developed a strong staff development system, which served as a solid foundation for providing high-quality services and building strong relationships with families. Most programs had made significant investments in staff training. Strong supervisory systems were also in place, with some programs providing regular, intensive individual and group supervision to front-line staff. Staff retention was good in most programs. In programs in which staff turnover was high, it was usually associated with changes in program leadership. Finally, no program reported low staff morale, despite the stress of program startup and significant leadership changes in several programs.

3. **The quality of center-based child care provided directly by research programs ranged from good to excellent.**

When the research programs provided child care directly in Early Head Start centers, the quality of care they provided was good and in some cases excellent. Across programs providing center-based child care, quality observed using the Infant/Toddler Environment Rating Scale (ITERS) was at least minimal-to-good in all programs (4.1 or above on the ITERS) and good-to-excellent in five programs (5.9 or above on the ITERS). The quality of child care provided by the Early Head Start research programs stands out in contrast to the quality of care infants and toddlers receive nationally.

The research programs' success in setting up child care centers that provided high-quality services early in the programs' development may be the result of several factors. Several of the programs that provided center-based care in fall 1997 had prior experience operating Head Start centers or other center-based early childhood programs. This experience may have helped them establish their Early Head Start centers and achieve good or high levels of quality relatively quickly. In addition, some programs were not fully enrolled during much of the period in which the classroom observations were conducted, and lower-than-planned child-teacher ratios may have made it easier for research programs to provide high-quality services in their centers. Most importantly, the level of quality observed in Early Head Start centers may be the result of the research programs' solid staff development systems. Staff in almost all programs received intensive training on infant and toddler care and were supported in working toward obtaining a Child Development Associate credential.[1] Likewise, supervisory systems were strong in most programs. In some programs, supervisors provided regular feedback to staff based on observations of service delivery.

4. Most research programs had established strong collaborative relationships with other community service providers.

The Early Head Start research programs quickly established themselves as key players in services for disadvantaged families with infants and toddlers. By fall 1997, most of the research programs had established a range of collaborative relationships and partnerships with other community service providers. In particular, many programs coordinated closely with Part C providers to serve children with disabilities. Some programs were developing partnerships with community child care providers. Many programs participated in or held leadership roles in collaborative groups formed to coordinate services in their community.

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[1] The Early Head Start National Resource Center has provided training known as "intensives" in infant-toddler care; week-long training for key program staff; annual institutes in Washington, DC, for key program staff; and identification and preparation of a cadre of nationally known infant-toddler consultants who work intensively with programs on a one-to-one basis.

C. LOOKING AHEAD

Programs are dynamic, and, like children and families, they grow and change. The patterns of implementation challenges and successes discussed in this chapter are those identified during the implementation rating process for fall 1997, when the programs were still very young. In 1997, within a year of their startup, the programs were actively engaged in providing services and working to implement their program designs. That six were already offering a full package of services--that is, were fully implementing a highly complex, new program--was a strong achievement. Another eight were not far behind and, for many others, the complexities of welfare reform meant that programs had an initial year (1996-1997) in which many social and community circumstances changed considerably. All of the programs began devoting considerable attention to examining their program models and, in some cases, began to modify their approach.

To learn about the research programs' development over time, we conducted another round of site visits in fall 1999 and used the information collected to assign a second set of implementation ratings (after updating the rating scales to incorporate clarifications about the revised Head Start Program Performance Standards that the Head Start Bureau had made since 1997). We also developed ratings for the quality of child development services, including assessments of child care provided by Early Head Start programs and community child care providers, and factors that contribute to the quality of child care and child development home visits. The continuing story of the development of Early Head Start will be told in the *Pathways to Quality* report. There, we will describe levels of implementation and quality of child development services in fall 1999 and trace their changes over time.

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APPENDIX A

IMPLEMENTATION CHECKLISTS

INDICATORS OF FULL IMPLEMENTATION FOR EARLY HEAD START PROGRAMS

Program: ______________________________

Date of Visit: ______________________________

General Criteria	Specific Indicators
SUBPART B--EARLY CHILDHOOD DEVELOPMENT AND HEALTH SERVICES	
CHILD DEVELOPMENT CORNERSTONE (§1304.20 CHILD HEALTH AND DEVELOPMENT SERVICES, §1304.21 EDUCATION AND EARLY CHILDHOOD DEVELOPMENT, AND §1304.24 CHILD MENTAL HEALTH)	
Program is providing all child development services required by the EHS grant announcement and HS performance standards. (§1304.20 and §1304.21)	The program is providing the following services directly, through contract with an outside provider, or through referral to an outside provider. (INDICATE THE MODE OF SERVICE DELIVERY AS FOLLOWS: DIRECT (D), CONTRACT (C), OR REFERRAL (R)): ___ Early education services (NAME OF CURRICULUM: ______________________) ___ Child development home visits (especially for families with newborns and other infants) ___ Parent education (NAME OF CURRICULUM: ______________________) ___ Parent-child activities ___ Comprehensive health services for children ___ Nutrition services ___ Mental health services for children ___ Periodic developmental assessments (NAME OF INSTRUMENT(S): ______________________) ___ Part- or full-day child care services for families that need child care ___ Referral to and coordination with Part H service providers Comments:

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Indicators of Full Implementation for Early Head Start Programs *(continued)*

General Criteria	Specific Indicators
Program has identified criteria for high quality with respect to each of these services and has assessed the quality of the services it offers, including services provided directly and those provided through referral or coordination with other providers.	DESCRIPTION OF THE PROGRAM'S CRITERIA FOR ASSESSING SERVICE QUALITY IN THE CHILD DEVELOPMENT CORNERSTONE.
Program activities are linguistically appropriate and recognize children's individual rates of development. Services are provided in an environment that respects gender, culture, language, ethnicity, and family composition. (§1304.21(a)(1))	Percentage of enrolled families: ___ whose primary language is not English ___ who receive child development services in their primary language SOURCE OF ESTIMATES: __________ Program: ___ Includes activities for families that foster cultural pride ___ Provides child development services in a manner that respects families' cultural and ethnic traditions with regard to child-rearing practices ___ Provides child development services that are tailored to the circumstances and backgrounds of individual families and children Comments:
Program activities provide opportunities for a variety of sensory and motor experiences, support social and emotional development, support emerging communication skills, support the development of self-awareness and autonomy, and promote development of gross and fine motor skills. (§1304.21(b))	Program activities and curriculum provide the following through center-based activities for children, center-based parent-child activities, or home visits (INDICATE THE MODE(S) OF SERVICE DELIVERY AS FOLLOWS: CENTER-BASED EARLY EDUCATION/CHILD CARE (C), OTHER DEVELOPMENTALLY APPROPRIATE CHILD CARE (OC), HOME VISITS WITH A CHILD DEVELOPMENT FOCUS (HV), AND/OR GROUP SOCIALIZATION ACTIVITIES THAT INCLUDE PARENTS AND CHILDREN (GS). MULTIPLE CODING IS APPROPRIATE. ___ Opportunities for a variety of sensory and motor experiences ___ Support for social and emotional development ___ Support for emerging communication skills ___ Support for development of self-awareness and autonomy ___ Opportunities for gross and fine motor skills development ___ Support for emerging cognitive skills Comments:

General Criteria	Specific Indicators
All children enrolled are receiving child development services on a regular basis. (§1304.21(a)(1))	Enrolled children receive child development services through the following modes of service delivery: Center-based early education services/child care ___ Hours per week or ___ Hours per month ___ Number/percentage of children Other developmentally appropriate child care ___ Hours per week or ___Hours per month ___ Number/percentage of children Home visits with a child development focus ___ Hours per week or ___Hours per month ___ Number/percentage of children Group socializations that include the parent and child ___ Hours per week or ___Hours per month ___ Number/percentage of children SOURCE OF ESTIMATE: ____________ COMPLETE FOR PROGRAMS THAT PROVIDE HOME VISITS WITH A CHILD DEVELOPMENT FOCUS: Time devoted to child development in a typical home visit is appropriated as follows: ___ Percent of time spent directly with the child ___ Percent of time spent with the parent and child together ___ Percent of time spent directly with the parent for parenting education ___ Percent of time spent on family social services ___ Percent of time spent on other activities (DESCRIBE) SOURCE OF ESTIMATE: ____________ Percentage of enrolled children who received any child development services within the past month: ___ PERCENT SOURCE OF ESTIMATE: ____________ Comments:

Indicators of Full Implementation for Early Head Start Programs *(continued)*

General Criteria	Specific Indicators
All parents enrolled receive parent education services. (§1304.40(c)(3))	Of those parents who have been enrolled in the program for at least one month, percentage who have received any parent education services: ___ PERCENT SOURCE OF ESTIMATE: ________________ Comments:
Center-based programs encourage the development of secure relationships by having a limited number of consistent teachers over an extended period of time. (§1304.21(b)(1)(i))	COMPLETE FOR PROGRAMS THAT PROVIDE CENTER-BASED CHILD DEVELOPMENT SERVICES. ___ Program assigns each child a primary caregiver Group size: ___ Infants ___ Number of caregivers per group ___ Toddlers ___ Number of caregivers per group ___ Percentage of direct care positions that have been filled by new staff members in the previous 12-month period Comments:

Indicators of Full Implementation for Early Head Start Programs *(continued)*

General Criteria	Specific Indicators
Program provides comprehensive health care for children directly; and/or program coordinates with a local health care provider to provide comprehensive health care for children, and case managers follow up to make sure that children receive comprehensive services; and/or program refers families to local health care providers for comprehensive health care for their children, and case managers follow up to ensure that children receive comprehensive services. (§1304.20(a)(1)(i))	The program: ___ Provides comprehensive health care directly; and/or ___ Coordinates with a local health care provider to provide comprehensive health care and case managers monitor service delivery; and/or ___ Refers children to local health care providers and case managers monitor service delivery ___ Collaborates with health care providers and parents to track well-child care, immunizations, and treatment plans Comments:
Program helps eligible families without health insurance to apply for Medicaid. Programs that do not provide health care directly arrange for care to be provided free or at low cost to EHS families. (§1304.20(a)(1)(i))	The program: ___ Assists EHS children and families in applying for Medicaid ___ Assists EHS families without Medicaid in obtaining free or low-cost health care Comments:

Indicators of Full Implementation for Early Head Start Programs *(continued)*

General Criteria	Specific Indicators
Families with infants and toddlers suspected of having a disability are promptly referred to the local Part H agency. Program coordinates with the Part H agency to develop individualized service plans for families with children with disabilities. (§1304.20(f)(2)(ii))	Percentage of children: ___ With a suspected or diagnosed disability ___ With a suspected or diagnosed disability who have been referred to Part H (IF LESS THAN 100 PERCENT, RECORD THE REASON.) SOURCE OF ESTIMATE: ________________ Program coordinates with the Part H services provider to: ___ Develop joint individualized family service plans ___ Coordinate services that families receive Comments
Program has secured the services of a mental health professional to regularly consult with program staff and parents. (§1304.24(a)(2))	Program has: ___ Secured the services of a mental health professional ___ A schedule or system in place for regular consultation with a mental health professional with program staff and parents Comments:

General Criteria	Specific Indicators
All children have a medical home; have up-to-date immunizations; have had a well-child examination; have received age-appropriate developmental, sensory, and behavioral screenings; have received treatment for illnesses; and have a follow-up plan for identified conditions. (§1304.20(a), (b), and (c))	Percentage of children who: ___ Have a medical home ___ Have up-to-date immunizations ___ Have had a well-child examination ___ Have received age-appropriate developmental, sensory, and behavioral screenings ___ Have received treatment for illnesses ___ Have a follow-up plan for identified conditions SOURCES OF ESTIMATES: ______________________ Comments:
Program has made arrangements for child care to be provided for all families that need it, either by providing care directly at the EHS center, by coordinating with a local child care provider to offer care at the EHS center, and/or by arranging for child care spaces in local centers and/or family child care homes.	Percentage of all program families who: ___ Need child care ___ Are receiving child care services SOURCES OF ESTIMATES: ______________________ RECORD NUMBER OF CHILDREN PARTICIPATING IN EACH TYPE OF CHILD CARE SERVICE AND DESCRIBE RATIONALE FOR REFERRAL TO EACH TYPE OF SETTING: ___ Total EHS children receiving child care ___ Center-based child care provided directly by the EHS program ___ Center-based child care provided by another agency through contract with the EHS program ___ Center-based child care provided by another agency to which families are referred by the EHS program ___ Family child care provided through contract with the EHS program ___ Family child care provided through a network of providers who are trained and managed by the EHS program ___ Family child care to which families are referred by the EHS program ___ Relative or other child care selected by the family independent of the EHS program SOURCES OF ESTIMATES: ______________________ Comments:

General Criteria	Specific Indicators
Program has developed a plan and criteria for assessing the quality of child care arrangements prior to placing children in care and for regularly monitoring the quality of care.	Program has identified a plan and assessment tools for: ___ Assessing the quality of child care setting prior to placing children in care (NAME OF ASSESSMENT TOOL: ______________________) ___ Monitoring the quality of child care arrangement on a regular basis (INDICATE FREQUENCY: _____) ___ Providing training and support to the child care providers it uses Comments:
SUBPART C--FAMILY AND COMMUNITY PARTNERSHIPS	
FAMILY DEVELOPMENT CORNERSTONE (§1304.40 FAMILY PARTNERSHIPS)	
Program collaborates with families to develop individualized family partnership agreements. Program systematically learns about families' involvement in other programs and, when appropriate, builds upon these plans and/or develops joint plans. Staff regularly monitor implementation and review and update the agreements. (§1304.40(a)(2-3))	Program engages families in a process of developing individualized family partnership agreements that : ___ Identify families' goals, strengths, and needed services ___ Describe timetables and strategies for achieving goals ___ Build upon plans developed by other programs ___ Are developed jointly with other programs when appropriate ___ Are reviewed and updated regularly (RECORD FREQUENCY: ______________________) Comments:
Program has developed individualized family partnership agreements with all enrolled families. (§1304.40(a)(2))	Percentage of enrolled families for whom an individualized family partnership agreement has been developed: ___ PERCENT SOURCE OF ESTIMATE: ______________ Comments:

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General Criteria	Specific Indicators
Case managers meet with each family in their caseload at least once per month. (§1304.40(b))	Percentage of families who have had a meeting with their case manager within the past 30 days ___ PERCENT SOURCE OF ESTIMATE: ________________ Comments:
Program services offered include the full range of services specified in the EHS program announcement and the HS performance standards. (§1304.40(b)(1), (c), (e), and (f))	The program is providing the following services directly, through a contract with another agency, or through referral to another agency [INDICATE THE SERVICE DELIVERY MODE AS FOLLOWS: DIRECT (D), CONTRACT (C), OR REFERRAL (R).] ___ Case management ___ Parent support through peer support groups and other approaches ___ Child development information ___ Health care ___ Comprehensive prenatal and postpartum care ___ Prenatal education and information about breast feeding ___ Mental health services ___ Information about mental health issues such as substance abuse, child abuse and neglect, and domestic violence ___ Services to improve health behavior, such as smoking cessation classes and substance abuse prevention and treatment ___ Education and job training ___ Employment services ___ Emergency assistance ___ Transportation to program services Comments:

General Criteria	Specific Indicators
Program has identified criteria for high quality with respect to each of these services and has assessed the quality of services it offers, including services provided directly and those provided through referral or coordination with other providers.	DESCRIPTION OF THE PROGRAM'S CRITERIA FOR ASSESSING SERVICE QUALITY IN THE FAMILY DEVELOPMENT CORNERSTONE
Program systematically monitors service quality and works to improve quality when deficiencies are identified.	DESCRIPTION OF THE PROGRAM'S PROCEDURES FOR MONITORING SERVICE QUALITY, INCLUDING FREQUENCY OF MONITORING AND FOLLOW-UP ACTIVITIES WHEN DEFICIENCIES ARE IDENTIFIED
Program actively tries to involve all parents in the program in some capacity. (§1304.40(d))	DESCRIPTION OF OPPORTUNITIES OFFERED TO PARENTS TO BE INVOLVED IN THE PROGRAM AND METHODS USED TO ENCOURAGE PARENT INVOLVEMENT
Parents are considered for program positions when there are openings. (§1304.52(b)(3))	___ Number of staff members who are current or former EHS or HS parents Comments:

General Criteria	Specific Indicators
Parents volunteer for program activities. (§1304.40(d)(3))	Percentage of parents who have volunteered for program activities in the past year: ___ PERCENTAGE SOURCE OF ESTIMATE: ________________ Comments: LIST TYPES OF VOLUNTEER POSITIONS THAT PARENTS HAVE FILLED.
COMMUNITY BUILDING (§1304.41 COMMUNITY PARTNERSHIPS)	
Program communicates regularly with other community providers and community organizations to secure services for program families and to work together to provide higher-quality services to all families. (§1304.41(a)(1))	___ Estimated number of other community providers with which the program communicates regularly ___ Average frequency of communications with other community providers ___ Participation in a coordinating group of community service providers SOURCE OF ESTIMATES: ____________________ Comments: DESCRIBE TYPES OF COMMUNICATIONS WITH OTHER SERVICE PROVIDERS.
Collaborative agreements are made to improve access to high-quality services by program families. (§1304.41(a)(2)	Program has in place (RECORD NUMBER): ___ Written collaborative agreements ___ Informal collaborative agreements SOURCE: ______________________________ Comments:

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General Criteria	Specific Indicators
Program has established a Health Advisory Committee and other advisory committees as necessary. The committees meet regularly to discuss program issues. (§1304.41(b))	The program has established the following advisory committees: ___ Health Advisory Committee ___ Other (DESCRIBE) Comments:
Program has established procedures for coordination and outreach to schools and other agencies that facilitate the successful transition of children enrolled in EHS. (§1304.41(c)(1))	DESCRIPTION OF PROCEDURES FOR DEVELOPING TRANSITION PLANS
Transition plans for all children are developed at least six months prior to the child's third birthday. (§1304.41(c)(2))	Of those children who are within six months of their third birthday, percentage who have a transition plan in place: ___ PERCENTAGE Comments:
SUBPART D-PROGRAM DESIGN AND MANAGEMENT	
STAFF DEVELOPMENT CORNERSTONE (§1304.52 HUMAN RESOURCES MANAGEMENT)	
Program has a staffing plan and job descriptions for each position that describe the minimum qualifications and selection criteria for the position. These criteria meet or exceed EHS performance standards. (§1304.52(a-f))	___ Job qualifications and hiring criteria meet or exceed EHS performance standards Comments:

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General Criteria	Specific Indicators
All line and supervisory staff receive training commensurate with their education and experience at least once a year. Whenever possible, training opportunities should provide academic credit. (§1304.52(k)(2))	OBTAIN INFORMATION ABOUT TRAINING, EDUCATION, AND EXPERIENCE FROM THE STAFF QUESTIONNAIRE, DESCRIBE TRAINING RECEIVED (INCLUDING OPPORTUNITIES FOR ACADEMIC CREDIT), AND LIST STAFF WHO HAVE NOT RECEIVED APPROPRIATE TRAINING IN THE PAST YEAR.
Program staff receive adequate supervisory support and mentoring to sustain motivation and prevent staff turnover due to burnout.	RECORD A DESCRIPTION OF SUPERVISORY, MENTORING, AND OTHER STAFF SUPPORT ACTIVITIES DESIGNED TO SUSTAIN MOTIVATION AND PREVENT BURNOUT. ___ Percentage of staff who have left the program during the past 12 months due to reasons other than program downsizing
Staff development curriculum and materials demonstrate that staff development activities reflect an interdisciplinary approach and an emphasis on relationship building and employ techniques and opportunities for practice, feedback, and reflection. (§1304.52(k)(2))	Staff development plan and curriculum: ___ Reflect an interdisciplinary approach ___ Emphasize relationship building ___ Employ techniques and opportunities for practice, feedback, and reflection Comments:
Staff receive training in multiple areas. (§1304.52(k)(3))	OBTAIN TRAINING INFORMATION FROM THE STAFF QUESTIONNAIRE AND DESCRIBE THE AREAS IN WHICH STAFF HAVE RECEIVED TRAINING LIST STAFF WHO HAVE NOT RECEIVED TRAINING IN MULTIPLE AREAS.

General Criteria	Specific Indicators
All program staff receive regular performance reviews and consideration for promotions. (§1304.52(i))	RECORD THE FREQUENCY OF PERFORMANCE REVIEWS AND PROVIDE A DESCRIPTION.
Staff salaries and benefits are at or above the average level for similar staff in area programs.	___ In the program director's opinion, staff salaries and benefits for EHS staff positions are at or above the average level for similar staff in other area programs. Comments:
1304.51 MANAGEMENT SYSTEMS AND PROCEDURES	
Program has developed multi-year program goals and short-term program and financial objectives. (§1304.51(a)(1)(ii))	Program goals and objectives: ___ Were developed through a collaborative planning process ___ Reflect the findings of the program's annual self-assessment Comments:
Program has conducted an in-depth assessment of community resources and needs. (§1304.51(a)(1)(i))	___ The program has conducted an in-depth assessment of community resources and needs within the past three years. Date of most recent assessment: ____________________ Comments:

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Indicators of Full Implementation for Early Head Start Programs *(continued)*

General Criteria	Specific Indicators
Program has developed written plans for implementing services in each of the program areas included in the HS performance standards. (§1304.51(a)(1)(iii))	___ The program has developed written plans for implementing services in each program area. Date of most recent plan revision: ____________________ Comments:
In consultation with policy groups and other community members as appropriate, program conducts an annual self-assessment of its effectiveness, its progress in meeting goals and objectives, and its implementation of the HS performance standards. (§1304.51(i)(1)	___ The program has conducted an annual self-assessment (covering areas described in J.3 of the protocol). ___ The program has used the self-assessment to make program improvements (DESCRIBE) ___ The self-assessment has been done in consultation with the policy group and other community members. Date of most recent assessment: ____________________ Comments:

APPENDIX B

IMPLEMENTATION RATING SCALES

EARLY HEAD START NATIONAL EVALUATION
EARLY CHILDHOOD DEVELOPMENT AND HEALTH SERVICES
IMPLEMENTATION RATING SCALE[a]
FALL 1997

Dimension	1	2	3	4	5
Frequency of child development services	Little or no evidence that families receive child development and parent education services on a regular basis (at least monthly).	Some families receive child development services and parent education on a regular basis.	Most families receive child development services and parent education at least monthly.	Almost all families receive child development services at least two times per month and parent education services at least monthly.	Almost all families receive child development services at least three times per month and parent education services at least monthly.
Developmental assessments	Little or no evidence that the program conducts or arranges for development assessments for children.	Program staff conduct or arrange for developmental assessments for some children.	Program staff conduct or arrange for periodic developmental assessment for most children. When a disability is suspected, program staff refer the family to a Part C provider.	Program staff conduct or arrange for periodic developmental assessments for almost all children. When a disability is suspected, staff refer the family to a Part C provider and work closely with the provider to coordinate services for the family.	Program staff conduct or arrange for periodic developmental assessments for almost all children. When a disability is suspected, staff refer the family to a Part C provider and work closely with the provider to coordinate services that the family receives and to develop joint service plans when appropriate.
Health services	Little or no evidence that the program assists families in accessing child health, dental, and mental health services and tracks well-child visits, immunizations, and treatment plans.	Program staff help some families access child health, dental, and mental health services.	Program staff ensure that all families have a medical home and have access to health, dental, and mental health services.	Program staff ensure that all families have a medical home and have access to health, dental, and mental health services. The program follows up to ensure that children receive needed services and immunizations.	Program staff ensure that all families have a medical home and have access to health, dental, and mental health services. The program follows up to ensure that children receive needed services and systematically tracks well-child visits, immunizations, and treatment plans for any identified conditions or illnesses.

1997 Implementation Rating Scale--Early Childhood Development and Health Services *(continued)*

Dimension	1	2	3	4	5
Child care	Little or no evidence that the program assists families who need child care in making child care arrangements.	The program provides some assistance to families that need child care by providing some child care directly, providing referrals to child care providers, and/or helping families apply for child care subsidies.	The program assists most families that need child care by providing child care directly, providing referrals to child care providers, and/or helping families find child care and apply for child care subsidies. When the program refers families to other child care providers, staff monitor the quality of care provided.	The program assists all families that need child care by providing child care directly, providing referrals to child care providers, and/or helping families find child care and apply for subsidies. Program staff assess the quality of child care before making referrals and monitor quality regularly to ensure that all children receive quality child care that meets HS performance standards.	The program assists all families that need child care by providing child care directly, providing referrals to child care providers, and/or helping families find child care and apply for subsidies. Program staff assess the quality of child care before making referrals and monitor quality regularly to ensure that all children receive quality child care that meets HS performance standards. If necessary, the program provides child care providers with the training and support they need to improve the quality of care that EHS children receive.
Parent involvement in child development services				Program staff involve parents in planning and providing child development services.	Parents work as partners with program staff to plan and deliver child development services.
Individualization of services				Child development services are individualized according to the unique circumstances, background, and developmental progress of each child and family.	Child development services are individualized according to the unique circumstances, background, and developmental progress of each child and family and are provided in a linguistically and culturally appropriate manner.
Group socializations				The program holds regular group socialization activities for families participating in home-based services.	The program holds regular group socialization activities for families participating in home-based services, and at least half of families participate regularly.

[a] The Early Childhood Development and Health Services Implementation Rate Scale was updated in 1999 to incorporate clarifications in program guidance from the Head Start Bureau between the fall 1997 and fall 1999 site visits. Although most items in the scale did not change, in a few instances the changes raised the "bar" for achieving full implementation. The revised scale will be presented in the forthcoming *Pathways to Quality* report.

EARLY HEAD START NATIONAL EVALUATION
FAMILY PARTNERSHIPS IMPLEMENTATION RATING SCALE[a]
FALL 1997

Dimension	1	2	3	4	5
Individualized family partnership agreements	Little or no evidence that the program systematically develops individualized family partnership agreements (IFPAs) with families and provides ongoing case management.	The program has developed IFPAs with some families and provides some case management to connect families with the services they need.	The program has developed IFPAs with most families, and most families meet with their case manager at least once a month. IFPAs include goals, an assessment of strengths and needs, and timetables and strategies for achieving goals.	The program has developed IFPAs with almost all families, and almost all families meet with their case manager at least once a month. IFPAs include goals, an assessment of strengths and needs, and timetables and strategies for achieving goals. Program staff review IFPAs regularly with families and update them as needed.	The program systematically develops IFPAs with almost all families that include goals, an assessment of strengths and needs, and timetables and strategies for achieving goals. Staff systematically learn about families' involvement in other programs and build upon these programs' plans whenever possible. Staff also conduct joint planning with other service providers when appropriate. All IFPAs are reviewed and updated regularly as needed.
Availability of services	Few family development services are available from the program or sought in the community.	Some family development services are available from the program or sought in the community.	The program provides services directly, contracts with other service providers, or refers families to most of the services they need.	The program provides services directly, contracts with other service providers, or refers families to most of the services they need. Staff systematically follow up with families and service providers to ensure that families receive the services they need.	The program provides services directly, contracts with other service providers, or refers families to most of the services they need. Staff systematically follow up with families and service providers to ensure that families receive the services they need. Staff also assess and monitor the quality of services families receive and work to make improvements when problems are identified.
Frequency of regular family development services	Few parents receive family development services.	Some parents receive family development services.	Most parents receive family development services.	Most parents receive family development services on a regular basis.	Almost all families receive family development services on a regular basis.

1997 Implementation Rating Scale--Family Partnerships *(continued)*

Dimension	1	2	3	4	5
Parent involvement	Few parents are involved in planning or carrying out program activities.	Some parents are involved in planning or carrying out program activities, and the program provides some volunteer opportunities for parents.	The program encourages families to become involved in planning or carrying out program activities, and many parents are involved in some capacity. In addition to participation in policy groups, the program provides a variety of volunteer opportunities for parents.	The program strongly encourages families to become involved in planning or carrying out program activities and provides multiple opportunities for involvement in policy groups and volunteer opportunities. Most parents are involved in the program in some capacity.	The program strongly encourages families to become involved in the program as decision makers, leaders, volunteers, and staff members. The program provides many opportunities for involvement in planning or carrying out program activities and facilitates families' participation in meetings and other program events. Almost all parents are involved in the program in some capacity.
Father initiatives				The program makes some effort to involve fathers in the program.	The program actively works to involve fathers in the program.

[a] The Family Partnerships Implementation Rate Scale was updated in 1999 to incorporate clarifications in program guidance from the Head Start Bureau between the fall 1997 and fall 1999 site visits. Although most items in the scale did not change, in a few instances the changes raised the "bar" for achieving full implementation. The revised scale will be presented in the forthcoming *Pathways to Quality* report.

EARLY HEAD START NATIONAL EVALUATION
COMMUNITY PARTNERSHIPS IMPLEMENTATION RATING SCALE
FALL 1997

Dimension	1	2	3	4	5
Collaborative relationships	The program has established few collaborative relationships with other service providers.	The program has established some collaborative relationships with other service providers.	The program has established many collaborative relationships with other service providers, and some of them are formalized through written agreements.	The program has established many collaborative relationships with other service providers, and some of them are formalized through written agreements. Program staff communicate regularly with other service providers to coordinate services for families.	The program has established many collaborative relationships with other service providers, and some of them are formalized through written agreements. Program staff communicate regularly with other service providers to coordinate services for families, and the program participates in at least one coordinating group of community service providers.
Advisory committees	The program has not established a health advisory committee.	The program has established a health advisory committee, but it does not meet regularly or is a preexisting advisory committee that does not focus on infants and toddlers.	The program has established a health advisory committee that meets occasionally to discuss infant and toddler issues.	The program has established a health advisory committee that meets regularly, involves other community health services providers, and discusses infant and toddler health issues.	The program has established a health advisory committee that meets regularly, involves other community health services providers, and discusses infant and toddler health issues. In addition, the program has established at least one other special advisory committee that focuses on infant and toddler issues.
Transition plans	The program has not established procedures for facilitating the transition from EHS to HS or other preschool programs.	The program has established procedures for facilitating the transition from EHS to HS or other preschool programs, but it has not followed them (for any children within six months of their third birthday).	Although the program has established procedures for transition out of EHS and follows them (for any children within six months of their third birthday), the procedures address only the transition from EHS to HS and fail to address the needs of families that are not eligible for HS.	The program has established procedures for facilitating the transition from EHS to HS or other preschool programs. All children who are within six months of their third birthday have a transition plan in place.	The program has established procedures for facilitating the transition from EHS to HS or other preschool programs. All children who are within six months of their third birthday have a transition plan in place. Parents are active participants in the transition planning process.

EARLY HEAD START NATIONAL EVALUATION
STAFF DEVELOPMENT IMPLEMENTATION RATING SCALE
FALL 1997

Dimension	1	2	3	4	5
Supervision	Staff receive minimal supervision, support, and feedback on their performance.	Most staff receive some supervision, support, and feedback on their performance.	All staff receive some supervision, support, and feedback on their performance.	All staff receive regular supervision, adequate support to sustain motivation and prevent burnout, and regular feedback on their performance.	All staff receive intensive individual and group supervision, support to sustain motivation and prevent burnout, and regular feedback on their performance that is based in part on observation of service delivery.
Training	Staff receive minimal training from the program.	Most staff have participated in at least one training session in the past year.	All staff have received training in the past year that is based on an assessment of their training needs.	All staff have received training in multiple areas in the past year. Training is provided according to a training plan that is based on an assessment of staff training needs.	All staff have received training in multiple areas in the past year. Training is provided according to a training plan that is based on an assessment of training needs. The program's approach to training emphasizes relationship building and provides opportunities for practice, feedback, and reflection.
Turnover	Staff turnover is very high.	Staff turnover is high.	Staff turnover is moderate.	Staff turnover is low.	Staff turnover is very low.
Compensation	Staff salaries and benefits are very low.	Staff salaries and benefits are low.	Staff salaries and benefits are at the average level for similar staff in other programs.	Staff salaries and benefits are above the average level for similar staff in other programs.	Staff salaries and benefits are above the average level for similar staff in other programs. Staff can access enhanced benefits such as tuition reimbursement, child care, or other "family-friendly" benefits.
Morale	Staff morale is very low.	Staff morale is low.	Staff morale is average.	Staff morale is high.	Staff morale is very high.

EARLY HEAD START NATIONAL EVALUATION
MANAGEMENT SYSTEMS IMPLEMENTATION RATING SCALE[a]
FALL 1997

Dimension	1	2	3	4	5
Policy Council	There is little or no evidence of a parent Policy Council.	A parent Policy Council has been established, but it does not meet regularly.	A parent Policy Council has been established and meets regularly.	A parent Policy Council has been established, meets regularly, and is involved in making decisions about the EHS program.	A parent Policy Council has been established, meets regularly, and is actively involved in making decisions about many aspects of the EHS program.
Goals, objectives, and plans	There is little or no evidence that the program has a plan for developing written goals, objectives, and plans for each service area.	The program has a plan for developing written goals, objectives, and plans for each service area, but these plans have been only partially implemented.	The program has developed goals, objectives, and plans for each service area. However, some of the goals and plans need to be updated.	The program has developed detailed goals, objectives, and plans for each service area. These goals and plans have been updated in written form.	The program has developed written goals, objectives, and plans for each service area. All written goals and plans are detailed, thorough, and up-to-date, and were developed in consultation with the program's Policy Council, advisory committee(s), staff, parents, and other community members.
Self-assessment	There is little or no evidence that the program has planned or conducted an annual self-assessment.	The program has a plan for conducting an annual self-assessment, but it has not taken significant steps toward implementing the plan.	The program has conducted a self-assessment in the past 12 months, but the self-assessment process needs to be formalized and documented in program records.	The program has conducted a formal self-assessment in the past 12 months. The results of the assessment have been documented in program records. The program involved a broad range of staff, parents, and community members in the self-assessment process.	The program has conducted a formal self-assessment in the past 12 months. The results of the assessment have been documented in program records. The program involved a broad range of staff, parents, and community members in the self-assessment process. The results of the annual self-assessment have been used to make program improvements.

1997 Implementation Rating Scale--Management Systems *(continued)*

Dimension	1	2	3	4	5
Community needs assessment	There is little or no evidence of a community needs assessment.	The program has a plan for conducting a community needs assessment.	The program has conducted an assessment of community needs and resources, but the assessment was conducted more than three years ago.	The program has conducted an assessment of community needs and resources. This assessment has been updated in written form in the past three years.	The program has developed an in-depth community needs assessment in the past three years. The program's Policy Council, advisory committee(s), staff, parents, and other community members were involved in the assessment process.

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[a] The Management Systems Implementation Rating Scale was updated in 1999 to incorporate clarifications in program guidance from the Head Start Bureau between the fall 1997 and fall 1999 site visits. Although most items in the scale did not change, in a few instances the changes raised the "bar" for achieving full implementation. The revised scale will be presented in the forthcoming *Pathways to Quality* report.

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